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ABSTRACT

The report--over half of which consists of appendixes--describes the Family Therapy Institute, a statewide program in Rugby, North Dakota devoted to the deinstitutionalization of juvenile delinquent status offenders by means of short term intensive family therapy treatment. Among the aspects covered are a history of the philosophical approach behind the institute; program goals and populations served; current program design (including the physical setting, length of stay, clients served, and a "typical stay") program setting; other resources serving youth; the climate for juvenile justice services in North Dakota; the therapy itself (including basic assumptions, conceptualization of family systems, staff support, supervision, and location of therapy); how families are referred; the program's organizational structure (including the agency and the staff); and funding (including budgeting). Also covered are Phase 1 of the program, which provides temporary shelter care for youth who otherwise would probably not be reunited with their families following a crisis; the program's followup component; and future directions. A discussion of program evaluation focuses on program statistics (including information on families, referred offenders, services provided, and referral sources), and evaluation of results (as seen by the institute, the families, and the referral sources and state network). The many appendixes consist of numerous charts, forms, and other exhibits. (DLS)

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THE FAMILY THERAPY INSTITUTE

A STATE-WIDE DEINSTITUTIONALIZATION PROGRAM

BEST COPY AVAILABLE

A documentation project of

the Child Welfare Resource Information Exchange

NOVEMBER 1979

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PREFACE

This paper is meant to serve those who are interested in learning about an effective program for youth. We have tried to make the style such that you will feel as if you have personally visited the Program by the end of the paper. It is not filled with "impressive" technical jargon--our intent is that our ideas can be understood and, therefore, readily utilized by any interested professional, even those new to the field of juvenile justice or programming for youth and their families.

The paper is desigend to lead you from planning to implementation, not only programmatically, but philosophically. If you have questions about specific areas (budget, structure, staffing), the Table of Contents can guide you quickly to your answer. Otherwise, the paper is designed to take you through the Program as our experience took us. It is also written as a beginning "how-to;" we have included as exhibits many examples of how we have specifically structured our Program. We know that any program which would use ideas presented in the paper would have to tailor them to suit its agency, location, staff, etc. We hope that the inclusion of this detailed information, however, may save you time and energy in attempting to set up the day-to-day operations of a program.

INTRODUCTION

The Family Therapy Institute is a state-wide program established in October 1978, with a primary purpose of deinstitutionalization of status offenders through short-term, intensive family therapy treatment. This approach developed from 6½ years of experience in delinquency prevention and diversion through the Department of Youth Services, a prior project, closely connected with the Second Judicial District Juvenile Court of North Dakota. The Family Therapy Institute is located in the Heart of America Human Services Center, an organization which encourages the co-location of agencies under a concept of cooperation and full service to clients. The Heart of America Human Services Center, Inc., along with the Good Samaritan Hospital Association and the Johnson Clinic, PC, form the Heart of America Medical Complex, which delivers comprehensive physical, mental, and rehabilitative services in one convenient cooperative setting. The Human Services Center was established as a "pilot project" for this type of complex in a rural setting.

The goal of the Family Therapy Institute Program is to maintain youth in their own home and community whenever possible, through the provision of services to the family that will mobilize the family's strengths to deal with the troubled youth. A parallel goal is to impact on the systems in North Dakota that serve youth, in a way that will change these systems from the way they have historically provided services to youth (i.e.--a philosophical change from nearly automatic removal of troubled youth to provision of services to the family).

Funding for this program was provided by the Office of Juvenile Justice and Delinquency Prevention, Law Enforcement Assistance Administration.

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I. HISTORY OF PHILOSOPHICAL APPROACH

A. Department of Youth Services 1973-1978

In 1973, the Second Judicial District Juvenile Court Judge created a Department of Youth Services in north central North Dakota. This Department worked closely with the Court in youth development/delinquency prevention programming. It was the assessment of the late Judge Ray Friederich that far too much time and energy had been spent for programs that dealt with "after-the-fact" services. As he presided over juvenile cases, he found that he saw many of the same offenders time and again. It seemed that the efforts of social services and law enforcement to help youth who were already in the Court system were not effective. He also observed that in many of the cases, there were indicators of potential problems in early years, such as school records that stated "lack of interest, motivation;" "doesn't seem to fit in well;" "poor social adjustment;" etc. It was his dream that the Department of Youth Services would serve as a preventative and diversionary arm of the Court.

The Department of Youth Services (DYS) was charged with seeking out little children with little problems; through this early identification process, we were to prevent these children from progressing along the path of failure and the resulting alienation from school and other social institutions that would result. The DYS also provided services aimed at diverting youth from the labeling process of the Juvenile Court by directly intervening in cases which would otherwise be handled in the Juvenile Court (i.e.--runaways, truants, minor delinquent offenders, etc). These goals were accomplished through two major efforts: (1) large scale volunteer tutor programs in the elementary schools to identify children, and to direct resources to children beginning to experience academic, emotional, social or motivational problems; and (2) a shelter-care facility where youth could be housed while services were provided which would divert the case from the Juvenile Court system.

Although these major programs remained constant throughout the existence of the DYS from 1973-1978, a major philosophical change occurred in those 6½ years. The DYS staff began the provision of services in 1973 with a very traditional approach--the approach of individual counseling, and services aimed at the troubled youth. Much time and energy was spent by the DYS providing the same type of services as other agencies had previously provided, but at an earlier point. Although this early intervention proved to be effective in diverting a significant number of cases from the Juvenile Court and in reducing the Court recidivism rate, the staff still saw a disturbing pattern. In many cases, counseling progressed rapidly during shelter care, but former acting out behaviors reoccurred shortly after placement back in the home. A number of youth were placed outside the family unit through informal agreements (without Court adjudication and labeling) and again, even if significant progress was made during placement out of the home, the youth's behavior regressed sooner or later when placed back in the home. Permanent placement was no solution, either, as it seemed that eventually even positive placements had to be ended for one reason or another, and the process began again. A pattern seemed to repeat itself time and again as we defined the reason for shelter care and/or for longer placement--family dysfunction.

In 1975, we began to move in the direction of a family treatment approach after being exposed to the "Sacramento 601 Project" and Dr. Roger Baron of California.[1] The "601 Project" diverted status offenders from detention hall, and from the court involvement which would have resulted, through immediate family crisis counseling and an offer of a maximum of five follow-up sessions. Although there was an average of only two follow-up sessions in this project, they experienced very significant results in a decrease in recidivism to the law enforcement system! This provided empirical data for what we had hypothesized--that we needed to involve families to see effective results in working with youth.

From 1975 to 1978, we initiated and maintained involvement with Dr. Baron and moved in the direction of the provision of family counseling.

B. History of Program Design

As before, in 1975 we began with a "traditional approach"--weekly family meetings that lasted 1-1½ hours. We found that not only was it difficult to get everyone in each time, but that we would just begin to experience progress as the session was over. By the next session, so many crises had occurred during the week, that the progress was lost. Many families had neither the money nor the resources to come weekly. We also felt that most families of adolescents who are acting out do not seek or get referred for help until they feel they have "tried everything," and they feel hopeless and exhausted. For their own sanity and to maintain the rest of the family, they feel it is best to remove the youth, not to talk of working it out so he/she can remain at home. We found that a weekly design did not provide the intensity to show the family enough improvement in family functioning to have the strength to try. For these reasons, we chose to plan for a short-term (3-5 day), but intensive treatment program.

II. PROGRAM GOALS AND POPULATION SERVED

The major reason behind all activity in our program is to keep families together wherever possible. We have spoken of the history of the lack of long-run effectiveness that we saw in out-of-the-home placements. Knowing that the child carried much of his family's system to any placement (often leading to placement failure) and also knowing that almost all youth eventually returned home we realized the meaning of the oft-quoted saying, "You can take the kid out of the home, but you can't take the home out of the kid!" If we were to meet our goal of keeping families together, we knew our objectives would be:

- To provide services which strengthened the ability of the family to provide appropriate control and support for the youth.

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[1]Roger Baron and Floyd Feeney, Juvenile Diversion Through Family Counseling, U.S. Department of Justice, February, 1976.

- To reunite families who had been separated due to lack of appropriate family services (to deinstitutionalize).
- To prevent the removal and placement (institutionalization) of youth whose families could not control or deal with the youth.
- To impact the systems (Juvenile Courts, Social Services, etc.) that handle these youth and their families, so that the more effective treatment, family therapy, would be utilized as an alternative to removal.

A. Types of Families Served

The criterion for acceptance into our program was established by guidelines set by our initial funding source. The Family Therapy Institute serves several categories of youth. Our first priority is the deinstitutionalization of status offenders.[2] For the purposes of our Program, "institutionalization" was considered any placement outside the usual family setting for that child, which included the State Industrial School ("reform school"), the State Hospital, group homes, foster homes, detention centers, and/or jails. Our second priority is to prevent the institutionalization of this same population. As resources permit, our third priority would be to deinstitutionalize or prevent the institutionalization of delinquent offenders.

III. CURRENT PROGRAM DESIGN

Our program, the Family Therapy Institute (hereafter referred to as FTI), brings status offenders and their families to Rugby to receive short-term, intensive family therapy. The following sections will describe our program components.

A. Physical Setting

The FTI provides a converted dormitory in which the families are housed during their stay (Exhibit A, page 26). Our facilities house two to four families at a time, depending on family size. The dorm contains a

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[2]A status offender is the counterpart of "an unruly child" in the North Dakota Century Code (Section 27-20-02.4), which provides the following definition: "Unruly child" means a child who:

a. Is habitually and without justification truant from school;
b. Is habitually disobedient of the reasonable and lawful commands of his parent, guardian, or other custodian and is ungovernable; or who is willfully in a situation dangerous or injurious to health, safety, or morals of himself or others; or
c. Has committed an offense applicable only to a child; and
d. In any of the foregoing is in need of treatment or rehabilitation.

kitchen unit, complete with everything necessary to prepare and eat meals, except groceries. Rooms are assigned to each family, and basic "courtesy rules" are explained, but responsibility for working out living space (shared kitchen, bathrooms) is left to the families. Although a list of staff on call is available (along with local emergency phone numbers), no staff are needed to "supervise" the dorm. Families care for their children at home, and they are expected to do so responsibly during their stay with us. (For family's reaction to the setting and philosophy, see "Evaluation" section.)

The dorm is on the same grounds as the Human Services Center, where the FTI offices and therapy room are located (Exhibit B, page 27), so all services are on the same block.

B. Who is Expected to Come to FTI

Our definition of "family" is all people who have a significant impact on the child in his home setting. Most often this includes those who reside in the home, and we include all siblings, having no minimum age. You will note that our definition easily includes others who may not live in the home, and we often request "significant others," who have a good deal of impact on the family system to attend, such as: (1) grandparents who are very involved in the family; (2) divorced parents who live away, but are still very much involved in the family process; (3) live-in parental or spouse figures (natural parent's girl-or boyfriend). Family members who are not living in the home and who are not closely involved in the family process are welcome to attend, but not expected to attend. (Further discussion of who is in therapy is found in Section V, entitled "THERAPY ITSELF!").

C. Setting the Date and Length of Stay

Our Program is open seven days a week and our busiest days, of course, are on the weekends. The decision to make family services available seven days a week seems an obvious one--to help families, we must be available at realistic times. FTI accepts families on certain days during the week, unless emergencies dictate admission otherwise. This allows us to assign staff and plan rooms in an organized way. (Exhibit C, page 28 is a sample of an FTI schedule of family arrival and staff assignment). We encourage families who are able, to receive services during the week, and many who are self-employed, unemployed, or who are high enough in their job structure, can arrange to come during the week. For those who can't (and we accept the family's decision), arrival is set for Thursday evening. Although we originally set our stay as two to five days, we have evolved to expect families for not less than a three-day stay. This extra day seems to solidify changes that are made. Occasionally we accept a family for two days, who absolutely cannot make other arrangements, but we suggest from initial contact that they will likely have to return for a follow-up visit. Very few families have stayed longer than three days--for those who need further services from us, we usually set up a "follow-up," since few can arrange to stay more than three days.

D. A "Typical Stay"

The family is advised to arrive by 10:00 p.m. on the pre-arranged night and to expect to stay until the afternoon of the third day. They have received a brochure in advance telling them how to contact staff upon arrivel (Exhibit D, page 29). They are met by an FTI staff member (initially we used therapists, but now use our para-professionals), who shows them to the dorm. They are assigned their rooms, the rules and cooperative situations for bathrooms and kitchen facilities are explained, a local map is given, and a time for the first session is set. If time permits, a session will be held the first evening to "get it over with" so everyone knows what to expect. Otherwise, a session is held the next morning. We do not encourage any families to arrive in the morning, since they are then "unsettled" and often tired from the drive and arrangements. We state that all families, even those from in town, must plan to stay in our facility, to allow all concentration and energy to be focused on the family--no last minute company, no phone calls, no business pops up in a new setting, to divert attention elsewhere.

Since our philosophy of treatment is to build families' competencies, their day is controlled by their decisions. Families decide how often and for how long they would like to meet. We encourage hard work by our willingness to work as much as we can. Contrary to almost all predictions, even the families labelled as "unmotivated", or "hostile" by referral sources, choose to meet three times per day, which is the usual number for all families. The sessions last as long as the family and therapists feel is appropriate, varying from twenty minutes to four hours; our average session is 1½ hours. Generally one session is held in the morning, one in the afternoon, and one in the evening.

Between sessions, the family is almost always given "assignments" to do that will strengthen the changes made in session. This might include family activities, things to write, time to be spent with certain people alone, etc. Aside from these therapeutic assignemnts, the families are responsible for their time. Certain recreational activities are available through FTI arrangements, such as croquet, swimming (at a local motel), or basketball. Families can take advantage of public recreational facilities, such as movies, bowling, museums, etc. Families are encouraged to spend time together, and to rediscover that they can have fun together.

To understand what the families usually experience in three days, you will be interested in the "Evaluation" section of our Program. But a typical stay now would have eight or nine sessions lasting 1½ hours, totaling 12-14 hours of actual therapy, which in itself represents three months worth of traditional weekly sessions; plus the family experiences a great deal of change through between-session-assignments, through the scheduled isolation from larger-world pressures, and through the pressure of being forced together as a family with no way to remain "uninvolved."

IV. PROGRAM SETTING

A. City, State

The Family Therapy Institute is located in north central North Dakota, in the town of Rugby (which is the Geographical Center of North America!). The population of Rugby is 3,500 people. North Dakota is a rural agricultural state, large in geographical area (70,665 square miles) and small in population (617,761 people). The services in our state are generally provided through the eight major cities in N.D., whose populations range from 7,078 to 53,365. (Exhibit E, page 30)

The question most often asked of our staff about the FTI program is, "Why Rugby?". Although this is answered in detail in the "Historical" section, a simple answer is that staff of a program previously located here (DYS) had searched in vain for a program in N.D. which served families. Finding none, we developed one, and since we were here, it is too!

B. Other Resources Serving Youth

The Juvenile Court of the state is the District Court, therefore District Court judges also serve as Juvenile Court judges. Each judge of the District Court may appoint juvenile supervisors as needed to conduct investigations, hearings and provide aftercare for offenders. The larger cities in the state also employ probation officers. The court makes the ultimate decision in juvenile matters brought to them, and each court utilizes the information presented by other agencies to a different degree in making decisions on its cases.

"North Dakota has only one state institution for the confinement of juveniles, the State Industrial School (SIS). It is one of the few co-educational institutions for delinquent youth in the nation... The initial hearing and adjudication of a child as unruly does not permit commitment to the State Industrial School. It is the further hearing which gives the Juvenile Court the authority to make a disposition to SIS. Since in nearly every status offense, the first hearing does not accomplish a complete rehabilitation, the Court is at liberty to commit to SIS upon the second or any subsequent hearings."[3]

Several larger cities have established juvenile detention centers within the last two years. However, in the largest share of rural North Dakota, detention is not readily available. In some instances, status offenders have been placed in emergency foster homes, but in the greatest number of cases that do not utilize Phase I of FTI, these youth are jailed.

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[3]Ray R. Friederich, District Court Judge, "Background," A Concept Paper, The Family Therapy Institute, July, 1978

The North Dakota State Hospital has a separate unit for the placement of adolescents, the Adolescent Center. There are 2 group homes for adolescent boys, and 2 group homes for adolescent girls. The Social Service Board of North Dakota through each county social service office, is responsible for foster care services. Although there are licensed placements for adolescents, very few teen-agers are actually placed. It has been our experience that foster home placements can seldom be considered as an alternative for adolescents, due to lack of available homes, which we feel has come about through lack of successful foster home experiences (for both adolescents and foster families).

It is our feeling that North Dakota is quite fortunate in having the placement options that are available. They seem to rank far above the standards reported in some other parts of the country. Yet even with these good placement options, service providers have continued to experience frustration in availability and long range effectiveness.

The agencies in ND which provide state-wide services for youth are the Social Service Board of North Dakota, through 53 county offices, and the Department of Health, through the 8 regional mental health and retardation centers, and their outreach offices. Through these 2 umbrella agencies, we are only aware of 2 other locations in ND where families receive family therapy as a unit (on a weekly basis). The bulk of services for youth are in the form of individual counseling for the youth.

C. The "Climate" for Juvenile Justice Services in North Dakota:

Historically, the thrust of most services aimed at youth were of a protective nature, in which the state "took over" the care of youth who were not being adequately provided for. This transfer of responsibility from parents to state happened in 2 major types of cases:

- abuse/neglect cases, in which children were abused or neglected by their parents according to the legal definition of abuse/neglect. These were almost always younger children (pre-puberty). Although parental rights were sometimes terminated, more often the child experienced a yo-yo effect, from foster home placements to placements back in the home and repeat... or the child would face a series of foster homes in a long-term foster-home-care plan;

- juvenile court cases, in which adolescents had committed status offenses or delinquent acts. The view of the state was that these children were "in need of treatment and/or rehabilitation," and that since the parents were (or seemed) unable or unwilling to provide such help, the state would provide it.

The problems in this philosophy and service plan were two-fold: (1) the lack of effectiveness of state-provided rehabilitation through removal as described previously, and (2) the lack of sufficient services to "take over" all the cases in which "rehabilitation" was needed! Waiting lists for foster home and group home placements grew--many foster homes found they could not provide what these adolescents needed--group homes were filled with adolescents

who were ready for more independent placements, but where?? Since no work was being done with the family units, what was intended to be "treatment" became "placement", and resources were filled. The State Hospital and State Industrial School spoke of "inappropriate placements"--youth who were not in need of these institutionalizations, but were often "dumped" there because of lack of alternatives! Social workers had large caseloads of children whose "care, custody, and control' was placed with the county office, and these workers attempted to "parent" these youth, responding to each crisis, setting rules, counseling until they were "blue in the face," and always with a feeling of steadily slipping backwards. These frustrations were handled in several ways--greater pushes for securing foster homes, better training of foster parents, talk of more group homes, more training for social services, etc. Some were tried, some were helpful, but none answered the problem.

Then began the cutback in money available for human services, and not only did programs not increase and expand, but services were cut in many areas. And now, with "Proposition 13" fever, almost all services have "zero budget growth" plans. The time for a more effective and less costly service had arrived. Plus, the courts, social workers, and others were just plain tired of taking care of other people's kids! The climate for returning the responsibility of troubled youth back to their families was perfect.

Nationally, great awareness had developed regarding institutionalization of youth and this impact was being felt (philosophically and in terms of funding) in the state service system. People were ready to spend less to help families do more.

V. THERAPY ITSELF!

There are a number of different theoretical approaches to family therapy. This paper does not propose to teach family therapy nor to endorse any particular theory. We feel, however that it is important to share our working philosophy so that those who are not familiar with any form of family therapy will be more able to understand what it is we attempt to do.

A. Basic Assumptions

Whenever social workers visit our program or whenever we present workshops on our program, we begin our orientation by sharing some of the basic assumptions and philosophies of treatment which we as a staff have identified as common grounds for our family therapy practice. Although this is not intended to be a complete list, we hope it will help you to understand the basis for our approach. Our basic assumptions are:

Every parent cares and wants to be a better parent. It is our experience when we worked with youth outside the family setting that our view of other family members became very distorted. Hearing only one side and seeing only the result of the family dysfunctions, we often felt angered by what seemed to be the parents' lack of caring or motivation to help us in our attempts to help a troubled youth. It seems so easy now to see that much of the parents' negative response to us, or lack of response to our request for help, was based on their feelings of inadequacy and their defensiveness because of their fear of failing, especially when they were being asked to help with something

they felt they had already failed at. It wasn't until we began to see all the members of the family together that we could realize the interconnectedness, and could begin to see the tremendous effort that almost all parents have put forth, trying in their own way to help their children. Seeing family members only sporadically as they came to pick up their child showed us only the angry side and the judgemental side. Having all family members gather in a room and begin to try to work out their problems shows us the very positive, very caring side that exists in almost every family if we take the time to see it. We have come to believe very strongly that every parent does care and does want to be a better parent (with the exception of those who are severely mentally ill and are unable to think beyond themselves) and that our job is to find that caring part of parents and to help them to help their child.

Clients have worth. Although this statement is spouted in most schools of social work and most social workers will tell you they believe it, we have come to experience this statement in a whole new way in family therapy. As helping professionals, if we really believe that those who come to us for help have worth, then our goal would be to help them to help themselves and not to feel that we are the solution to their problem. Too often, our solution was to take over for the family and attempt to do what they seemed unable to do. The choice of this "taking over" as a solution was proof of our feeling that many clients (in this case, many parents) did not have worth, couldn't be helped and weren't able to be made responsible for their own children. Although many professionals profess to be non-judgemental, it is only when we can accept that almost every natural parent can be helped with our support, that we will in fact be practicing the concept that clients are worthy.

Brief intervention is our goal. We believe that therapy should not be a way of life. Too often, we had "assessed" individual or family problems based on what we felt the family should or could be. Too often, we wanted to continue to work with youth or families because we saw so many areas in which they could still improve. We have come to realize that there is not a family anywhere that could not find an area in which they could improve, and we have come to accept that the goal of therapy is not to solve all probelms or even to solve any one problem totally, but to provide families with enough support and direction to solve a current problem by learning a new process for dealing with it. Much has been written in crisis intervention theory about the greater movement and greater motivation to change when people are in crisis. We also believe that there will be greater movement and change when poeple are feeling discomfort and that once you have helped them to find a better way to deal with it, your time is better spent in helping others to overcome current problems rather than to continue long-term therapy with a family which has reached a level of function which is satisfactory to them. This is not to say that we do not believe in follow-up. We recognize the importance of follow-up, and practice it with a number of families, but with a time-limited goal selective plan, to assure that families do not begin to depend on therapy.

Clients are not fragile. Our biggest fear as we began family therapy was that we would somehow irreversibly harm a family, or cause the family to experience a crisis which would make things worse. We especially felt that our hands were tied when multi-problem families would come to us. We would see a very depressed parent, families who have lived through a number of divorces

or family breakups, or "hard-luck" families which experienced one crisis after another. Many times we felt that with this kind of background, the families wouldn't be able to take much more; we felt that we had to proceed quite cautiously in working with them. What we have come to realize is that these clients, whose strength seems so tenuous at times, are no doubt ten times stronger than any of us could be! As we examine the family history and see what they have lived through, it seems likely that those of us who practice in the profession would long since have given up, gone crazy, or buckled under. Time and again we have had to realize how strong these families are because of what they have been able to live through, and we marvel that they have survived as well as they have.

The ultimate power to change lies within the family. Frustrating as it may seem to those of us who would like to help, a family system can always be stronger than the therapy that any of us can provide. Therefore, if we do not help the family help itself they can resist change or undo whatever therapy we may try to do with a single family member. As we have realized the family's combined strength, it has freed us from protecting the family, which has allowed us to be able to confront families in a way which can be helpful. This is not to say that we feel that anyone should have license to see families without the benefit of training and input from other professionals, since "they wouldn't be able to hurt them anyway." But it does mean that we have found that often we were overly cautious of hurting families and our caution made us move so slowly that, in fact, we ended up not helping them at all.

Compentency-based therapy is far more effective. There are as many ways to approach family therapy as there are ways to skin a cat. It has been our experience that the most helpful change in how we look at clients, is that we practice a competency-based rather than a pathology-based therapy. This means that we look for family strengths and focus on strengths rather than focusing on weaknesses. Almost all parents who come to us have felt blamed by the helping system, guilty, and as if they have failed. Our approach is to build the parents' confidence by seeking their competence and encouraging success, rather than focusing on those things they do not do well. As may seem obvious, it is often the things they do not do well that have caused the family to end up in therapy; therefore, these things are discussed, but our choice has been to discuss them in a way that builds the family's belief in themselves and in their ability to deal with the situation, by providing positive input and direction.

These assumptions are obviously our ideal outlook. They represent somewhat of a "Pollyanna view" of how we strive to work. In the real world, obviously there are exceptions, and days of pessimism and feelings of hopelessness and helplessness. We have found, however that our overall experience has maintained our belief in these assumptions.

B. Conceptualization of Family Systems

We conceptualize family dysfunction from a systems viewpoint. We would liken a family system to a common hanging "mobile" (Exhibit F, page 31).

A mobile is one unit, composed of different parts. Each part is connected to all other parts in a way which keeps the system in balance. Each part can carry a different "weight," have a different characteristic or personality, and/or a different size. It is the placement of the parts that balances all these differences into one system, which will return to a balance no matter in which direction the system moves or is moved. Each unit is connected to the whole at a specific point, sometimes sharing a connecting tie with another unit; it will be close to some parts, distant from other. Although a mobile appears very delicate with its meager connections, in fact, it is a very strong system; it can withstand a great deal of movement, in almost any direction, and in a number of directions at once, and still return to its balance. Its flexibility, which makes it seem so fragile, is its strength! The overriding theme is that you cannot change any part without causing movement and reaction in every part. Because of the way a particular mobile is structured, different units will be affected to different degrees in different ways, but all will be affected by a change in the system.

The connection between mobiles and families is obvious. Each statement about mobiles is also true of family systems. (If this is not clear, re-read the preceding paragraph substituting family member for "part" or "unit" and family for "system.") Our philosophy is that every family has some homeostatic "balance," a way of relating and handling movement. Families come to us in crisis, when they are unbalanced; our job is to help the family find their former balance, or to establish a new balance if the units have somehow moved; as in a divorce (missing member); new marriage (new member); or during life stage transitions (child becomes adolescent and former "balance" is lost).

It is our belief that most young people who come to the attention of law enforcement or human services agencies can best benefit from family therapy for two reasons:

(1) The difficulties they are experiencing will have an impact on all other members of the family, so all need to be involved in helping in a positive way.

(2) Often the youth has come to our attention because of stress in the family that is causing his/her acting out behavior. To treat the behavior outside the context of the precipitating family cause will not solve the problem.

Because of the degree to which each person's behavior is tied to and related to another's movements, we feel that it is almost always advisable to see the whole family together at the same time. Although in rare situations we choose to see individuals (such as single parents) or dyads (such as a married couple) for brief interventions, the therapy is still systems-centered, and these interventions are made to have a particular impact on the family system.

We also believe that all members should be included, no matter what age. Much can be learned from how the family reacts, not just what is said. In a particular case, an acting-out adolescent stated she felt unnoticed, not important, and unable to speak to her parents. She and her parents then talked together very effectively and caringly, and we were at a loss to see the source of the adolescent's feelings. When we added their non-verbal two-year-old to therapy, the two-year-old provided the key to the dysfunction. When any

attempt was made for the parents and adolescent to talk, the two-year-old began a series of distracting behaviors, and over and over the pattern would repeat itself, always with the two-year-old winning the attention.

Family therapy theory states that there are ways of interacting that occur time and again in families, which constitute the family's process or structure. Our goal is to help them to experience a new way to function so that their old process or structure can be changed, and their family can be brought back to, or find a new balance. Although many families will also find new insights into their interactions, the key is not on new insights, but on new behaviors. It is an active therapy, which does not dwell on how they think or feel only, but moves to what a family will say or do while they are at therapy to have the situation get better. That is, we focus on a way to have them experience a more positive way of interacting IN THE ROOM--with these feelings of success, they can overcome the hopelessness and feelings of failure so that a new process will begin.

To understand what is meant by changing a family's process or structure, we need to look at the difference between "content" and "process." Content is the things that happen, and what is said; process is the way things happen and how they are said. Too often, helping professionals ignore obvious indicators of process while "searching for what psychologically propels" a youth's behavior. In family therapy, the process will show itself. If a teenager is out of control, a therapist would attempt to have the parents find out what the problem is. More than likely, a "content" issue will be raised ("Your rules are too strict; I want to be able to stay out until 1:00 a.m.!"). As the parents and teenager begin to try to discuss this content issue, many family processes could show themselves, for instance:

- *in fact, there are no established rules in this family, so the teenager always feels guilty, and is aking for a process whereby he/she knows what to expect; or*

- *that mom and dad do not agree on hours, and the youth is, therefore, never in the clar; they are in the middle, always blamed or condoned by one or the other; or*

- *that although there is a rule, the teenager never follows it anyway; a classic example of this family is a teenager who complains about how tough the rules are, and while the therapist "helps" the family discuss this content issue, the rest of the kids tear the therapy room apart, showing the real family process--no one is in charge!*

Our task, then, in family therapy is to listen to the content, but "hear" the family process, which is currently out of balance; then to help the family experience a new, more successful way to function, so that a re-structuring of the family can occur to regain a balance. (If you're interested in reading more about family therapy, we recommend the books listed in Exhibit G, page 32)

C. Staff Support, Supervision, and Location of Therapy

One of the most important aspects of our program (which is very hard to describe on paper) is the high level of support and encouragement that all

members of our staff give to other staff members; there is a spirit of caring, cooperation, and willingness to help that sets the tone for families when they arrive. If you have begun to believe the importance of the family system on how a member acts, you can also see how the system in which helping professionals work has a major impact on how we act, and therefore, the sense we give clients of what we can do. If your system lacks communication or organization, or is high in competitiveness and fear, the quality of therapy you can offer (as a whole program) will suffer.

Activities which foster a positive agency attitude can be built into a system. We began the provision of family therapy with the use of co-therapists, which encourages interdependence, mutual problem solving, and team work. Our training program, like our therapy, has been competency-based heavily emphasizing success, which energizes the staff for study and work on difficult cases. Co-therapy teams have been rotated, to maximize the learning which occurs in working with people who have different strengths to offer.

The therapy room itself lends itself to on-going support and training. The decor is comfortable, not like an "office"--carpeting, pictures on the walls, "non-government issue" swivel chairs--to make families open to a different type of therapeutic experience, since many have spent much time (although not as a group!) in social workers' offices. Also included in the therapy room are two cameras, two mikes, and a one-way mirror. Your reaction is--"How, then, can the family ever be comfortable?" We have found that although many are nervous at first, almost all agree they soon forget. The video-taping is optional, of course, and each family is asked to sign a video release form before taping begins (Exhibit H, page 33). As we explain to the families, the tapes are used to provide better services to families--by therapists reviewing their work, or by showing particular parts for staff in-service to improve our quality of service. At times, the tapes can be used to help the family see themselves as they are, and tapes can be viewed by family as it seems beneficial.

Live supervision is provided during most sessions. During the first nine months of therapy, supervision was provided primarily by the Program Coordinator and secondarily by the Assistant Program Coordinator. This immediate feedback was a very important part of on-going training for our staff who came from a variety of human service backgrounds, but with no previous training in family therapy. We have now moved to a system of peer supervision, in which all staff rotate turns at supervision from the more objective stance behind the mirror. We are also now having therapists "solo" with families as family needs and staff schedules permit. (The use of co-therapists or individual therapists in family therapy is a matter of great controversy. We feel both approaches have pros and cons, and will only say that for our staff at the time, we feel co-therapy was the best beginning experience.)

VI. HOW FAMILIES ARE REFERRED

A. Referral Process-(Exhibit Ia and Ib, pages 34 & 35)

By design, our program is informal; our referral process reflects this. Our priorities (listed in the section entitled, "II. A. Types of Families Served") and the guidelines of our grant form our criterion. Referral agencies were provided with copies of our service brochure (Exhibit J, page 36) at

workshops, in mailings, and through our contacts with all Juvenile Courts. Appropriate referrals are accepted from any sources--institutions, all levels of Juvenile Court personnel, social service and mental health agencies, clergy, and/or families who have heard of the program. A referral is made by a telephone call to the person responsible for intake (Program Coordinator or Assistant Program Coordinator). The information is gathered on a referral form (Exhibit K, page 37) which determines the appropriateness of the referral, and if appropriate, the staff gather information about the family structure so that staff and rooms can be reserved when a date is set. All referrals are also logged on a referral log, (Exhibit L, page 38) which provides quick feedback on the number of open referrals, their status, and any need for action.

We expect that the referring agency will discuss the possibility of family therapy with the family either prior to or after a referral call. Once this is accomplished, a member of our staff also contacts the family to gather any needed information, to send a family brochure, and mostly to reassure them, through personal contact with us. If a family is not ready to come,we "hold" the referral, recontact the family at a later date if they are willing, and notify the referral source. If the family agrees to come, a date is set according to the availability of staff time and rooms. (Refer back to Exhibit C, page 28)

B. Network Development

The first step in the referral process, or course, was to inform the system which already served youth, of our program and how it would fit into the network of services. Since youth can be referred anywhere along the continuum of no-helping-system-involvement to formally-adjudicated-youth, we needed to be in contact with and cooperate with a number of different kinds of agencies. We saw the provision of family therapy services as being an additional resource available in the state, rather than a duplicated service competing with any agencies, since this type of service was not available anywhere else in our state. We realize that the Juvenile Courts would have the greatest impact on whether children could be deinstitutionalized, or prevented from being removed, so our first step was to sponsor a workshop in Rugby for all juvenile supervisors in North Dakota to explain our Program and to gather input regarding how and when they thought out services might be useful to their Courts. This was followed by assignment of FTI staff to various Juvenile Courts to do further program outreach and follow-up. A linkage was developed with the North Dakota State Industrial School; a workshop was held for SIS staff, and appropriate referrals were identified. An FTI staff member was assigned as the FTI/SIS liaison to oversee continued involvement.

While staff travelled to juvenile courts, other agencies were contacted, and many visited personally, or invited to pre-arranged meetings. This fostered the development of relationships with agencies that provided placements and individual therapy, so that methods could be worked out for cooperation and referrals. We sponsored a total of 5 workshops on family therapy, which drew a number of professionals from a variety of agencies, and provided a vehicle for further network development.

We also selected one juvenile court system on which we focused additional staff resources to determine (for future planning) if such allocation would be beneficial. The largest court was selected, since it had also referred the greatest percentage of cases (interestingly, it is one of the longest distances from our program--4 hours by car). We found that additional involvement with this court had many benefits:

- the maintenance of a consistently high referral rate;
- a greater variety of cases referred that wouldn't have been considered without input from our staff;
- a greater depth of understanding of how to help families after FTI involvement;
- a greater use of family therapy theory in individual caseload; and
- a greater number of "difficult to get" families were actually convinced to come to therapy.

VII. GETTING FAMILIES IN!

Our experience has shown that the most important component in getting families in is the work you do first with agencies and other professionals! Just as a family can best help itself because it knows it's members better, so also, a local agency can best help to get a family to you, since they will know the family and community traditions best. They will only be helpful in this way, however, if they have been "convinced" of the worth of the approach of family therapy. You will hear many of the same arguments (about why a family can't come) from the agency, as you would from families--"It's been going on for 15 years, what can you do in 3 days?," "We've tried everything, I don't think this will do any good," "It might work for certain really motivated families, but this family is different!". In the process of developing linkages in the existing service network, therefore, you need to encourage questions and disagreements, and present facts in a non-defensive way. Remember that if this agency has been working with a family, they have something to lose, no matter what happens--if the family doesn't come, they remain stuck; if the family comes and does not feel "successful," they will feel responsible; if the family comes, and does experience a feeling of success, they feel as if they failed at something someone else could do. Relationships with referring agencies should be nutured and protected.

In terms of the family itself, we find that it is important for staff to call all families. For families who are already planning to come after discussing it with their local referral source, it offers a chance to answer questions, give them more accurate information and, we found, it decreases the chance of a cancellation. For families who are "thinking it over," remember that your staff understand the program best, and therefore can best present it to families who are fearful of coming. Our most significant discovery was that our initial approach encouraged people NOT to come. We were so trained to be empathic, that we found ourselves saying, "I know it's harvest and I'm sure you're very busy, but I was wondering if you could possibly?..." We gave the family all the excuses needed to say, "NO!" In order to be effective in getting people

to commit themselves over the phone, we believe staff should:

(1) assume that parents will want to help, and speak to them in that manner;

(2) assume that all "excuses" are reasons, and need to be dealt with seriously;

(3) present the program for its merits, not push, but offer it as you would any good deal;

(4) ask parents what they plan to do about their situation if they refuse to come (to show you expect them, not some agency to be responsible); and

(5) not accept a list of "I would, but..." as a negative answer. Deal with each "but..." seriously and continue to ask, "When will it be possible?"

Your best tool will be satisfied families. Many of the families that we served have volunteered to talk with other families who are hesitant. Families will also tell you what brought them--use this feedback in improving your "telephone salesmanship" to new families.

VIII. ORGANIZATIONAL STRUCTURE OF THE PROGRAM (Exhibit M, page 39)

A. Agency

The funding for the Family Therapy Institute comes from a grant from the Office of Juvenile Justice and Delinquency Prevention, Law Enforcement Assistance Administration, Washington, D.C. This funding is channeled through the County Commissioners of Pierce County (the county in which FTI is physically located), to the Heart of America Human Services Center, Inc. The Human Services Center is a private, non-profit corporation governed by an eleven member Board of Directors, elected from throughout the Center's service area. The Human Service Center Board monitors the expenditures of the grant by the Family Therapy Institute and provides programming input to FTI. The FTI also has a nine member advisory committee, whose members reside throughout the state. This advisory committee pursues the development of long-term funding strategies, assists in statewide network development, and provides programming impact.

B. Staff (Exhibit M, page 39)

The Executive Director of the agency is responsible to the HAHSC Board of Directors and is responsible for the administration of the FTI program, including planning for future funding, completing all budget-related tasks and all administrative functions required by the funding source, assisting in program planning and evaluation, and in general, being ultimately responsible for the direction of the program.

The Program Coordinator is responsible to the Executive Director, and is responsible for the quality of therapeutic services provided to clients.

Responsibilities of this position include the development (with staff input) and supervision of all activities in Phases I and II, plus providing therapy in some cases.

The Assistant Program Coordinator is a regularly scheduled therapist who also provides the intake and staff assignment functions, and is directly responsible to the Program Coordinator.

The Therapists (6 full-time, including the Assistant Program Coordinator), provide the actual family therapy services. They are also responsible to provide input on an on-going basis regarding their evaluation of the program, and to provide recommendations for change. They are now responsible to participate as rotating peer supervisors, and in on-going internal in-services. They are responsible to the Program Coordinator.

The five Houseparents provide supervision and activities for youth housed in Phase I, our temporary shelter care facility. They participate in FTI staffings, and also provide the families' link to FTI-arranged recreational activities, such as swimming. They now welcome families to FTI and provide the orientation to the dorm situation. They are under the supervision of the Program Coordinator.

The FTI employs a Business Manager/Executive Secretary, who is responsible for all Institute information and records. A Clerk/Receptionist accepts all incoming phone communications, receives the public, and provides typing and zeroxing services as needed by staff.

One of our houseparents doubles as the maintenance staff person and provides all maintenance functions in Phase I and II living quarters.

IX. FUNDING

A. Budget (Exhibit N, page 40)

This budget represents the money expended by the FTI in a 12-month period.

B. Budget Narrative

1. Personnel: The various positions and their responsibilities have been previously described. Our minimum qualification for therapists was a baccalaureate degree in a human service-related field. There were almost no "trained" family therapists available in North Dakota, and we felt that rather than having to "untrain" workers who already had notions of service provision in agencies with other philosophies, we would progress more rapidly with applicants who were new to the field, excited about the idea of family therapy, and who could learn fast.

Our houseparent qualifications varied from a professional social worker to a person who had been involved in the Juvenile Justice System as a youth

and had been removed from the home. The houseparent's personal strengths and ability to relate to youth and handle crises were the most important factors.

The Executive Director and Program Coordinator had both been involved in the Department of Youth Services Program, thus had 5½ years of experience in working with youth and their families.

2. Contractual: Dr. Roger Baron was hired as a consultant/trainer, to visit the program on a regular basis. His rate was $25/hour ($200/day) plus expenses.

3. Rent: (See Exhibits A, B, & O for diagrams of space rented)

4. Telephone: Since much of our referral work is done via the telephone, this category was very important. Staff were encouraged to make calls on the weekends they were scheduled to work to minimize costs. Our follow-up information from families and to referral sources is also done by phone.

5. Travel: This category includes travel for network development (to Juvenile Courts, etc.), to provide workshops, some consultant travel, and staff development and training travel funds. It also included money that could be used to reimburse families for travel expenses who otherwise would not have been able to attend therapy.

6. Equipment: This category included the purchase of our video-tape system, used for supervision and training.

C. Non-Budget Expense: Training

An additional $13,000 worth of training was provided through the Child Welfare Resource Information Exchange through their Technical Assistance program, and through funding received from the North Dakota Law Enforcement Assistance Administration. With these funds, additional training was provided by Dr. Baron and by Jodi Cox, Philadelphia Child Guidance Clinic.

We felt very strongly that if a trained and experienced family therapist would not be available on staff to provide training and supervision in a program providing family therapy, that funding MUST by secured to provide on-going consultation and training from an outside resource. The FTI also encouraged and partially funded attendance by FTI staff at family therapy workshops and practicums.

X. PHASE I

It had been our experience in working with youth that often they were removed from their homes during or immediately following a crisis. Our goal was to impact on removal of youth through family involvement, but we realized that families would need time to make arrangements (at work, school, etc.) before they could come to therapy. Phase I has provided temporary shelter care (up to 96 hours, unless extenuating circumstances necessitated a slightly longer wait) for youth who otherwise would probably not be reunited with

their families following a crisis (being picked up by the police, running away, etc.) North Dakota chose not to participate in the Juvenile Justice Act of 1974, so without our facility, there would be no alternatives available to some law enforcement agencies, but to place these unwanted youth-in-crisis in jails. So, although a viable family therapy program patterned after FTI could be implemented without shelter care, our Phase I has provided a service that is not available in the majority of towns in North Dakota.

When a youth is brought into Phase I (Exhibit O, page 41) the youth is seen by a professional staff member to assess runaway and suicide potential. This assessment information is given to houseparents (Exhibit P, page 42). Then any special rules are set by the therapist (Exhibit Q, page 43). Our facility is an apartment is and NOT locked (in 6½ years of shelter care and over 340 adolescents, we have had only one youth run from the facility!). The houseparent gathers intake information, medical information (Exhibit R, page 44), and advises the youth of our general rules (Exhibits Sa & Sb, pages 45 - 46). Each houseparent logs information (Exhibit T, page 47) at the end of his/her 8-hour shift (An example of our houseparent shift schedule is included as Exhibit U, page 48).

Educational activities have been developed for Phase I youth, based on gaps in learning we have seen over the years in the population we serve. These activities include staff-developed and client-tested games dealing with sexual activity, nutrition, social adjustment, general physical health, and alcohol and drugs. Counseling services are provided only as necessary to maintain the youth safely in our facility, as we have found that more in-depth individual counseling by our staff decreases the youths' participation in family therapy.

Since our focus is on keeping families together, we do not encourage the use of Phase I. When possible, we ask families to arrive as a unit. However, if the youth and/or his family are not willing to be together, or if a placement would be made without Phase I intervention, it is used. Whenever Phase I is not needed to house youth, we schedule families to stay in the Phase I apartment, so that we are able to house the maximum number of families (4) which our staffing scheduling permits.

XI. FOLLOW-UP

Throughout the therapy sessions, staff provide feedback to families on their process and their struggle to experience new and different ways of interacting. Because assessment, planning, and evaluation are on-going, "contracts" are made between the family and therapists often during the stay. As the stay nears the last half-day, discussion is held on what resources the family may need, if any, to maintain changes made. The family then decides what they will do for follow-up.

Many families have a "regular" social worker or court worker who has followed their youth's case for some time and who will remain involved. When this is the case, this worker is always invited to attend the FTI stay with the family and participate in the experience as a co-therapist and/or observer. This is the follow-up option that we feel is most helpful to the

family. If this worker (who by now is no doubt part of the process) does not attend, they will treat the family with the same techniques, which will probably unknowingly encourage the return of old patterns. While the worker is at the FTI, we share basic assumptions and they come to understand the general concepts of family process and the road to change. This worker is now able to be helpful in maintaining the new family system. We have also found that at FTI they see the family in a different, much more positive and hopeful light, since they previously had only heard "one side," and seen failure.

We encourage the utilization of any existing local services that the family is considering. There are several areas of the state in which some form of family therapy is practiced, and when possible, we encourage families to continue to seek services as a family.

Families are always welcome to return to the FTI, and many contract for a return date before they leave. We do not view a return as a "failure"--a family may have reached a certain step and may wish to climb further, they may experience a new crisis, or they may need a "booster shot" to maintain changes. Many say they plan to return because they enjoyed it very much and it provided a much needed family "time-out." We reserve space and staff for one follow-up family per weekend, and others may come, as they are able, during the week.

Not all families who plan to return actually end up returning. Again, we do not view this as their "failing" to follow a plan. For some, they were very leery that the changes could be maintained, and a scheduled return was their "insurance." The fact that they don't return is evidence of their confidence in themselves and the success of their work. Others are too busy, back in a normal busy schedule, and won't return unless a crisis occurs. We believe therapy does not need to be a way of life, and we encourage independence in families.

After a family's stay at FTI, the referral source is contacted by telephone the day after the family leaves to provide immediate feedback if the family has signed a Release of Information (Exhibit V, page 49). This is followed by a written report (Exhibit W, page 50). Referral sources are asked to keep us informed of any developments in the case, in the event we can provide further services. One of our frustrations has been referral sources who do not call when a crisis occurs, and who place a youth because "I already tried Rugby," when often the family would return with some encouragement and if the worker did not immediately offer an "easy way out"--removal. Families are followed up by telephone, and information is kept on a contact sheet in each file (Exhibit X, page 51).

XII. EVALUATION

A. Program Statistics

In order to evaluate what we have done, we will present statistics on what has occurred. Although the FTI program was funded as of October 16, 1978, we began with a 3-month "start-up" period of readying the physical plant, planning

final program details, hiring and training staff, etc. The statistics we will present are for the 10 months that the program has been providing services to families, January 17--November 17, 1979.

1. Information on families: A total of 126 families participated in the FTI program. This included 243 adults and 321 children, for a total of 564 clients. These families came from 22 out of the 53 counties in North Dakota. In 37 families there was a single parent, but in 72 of the families the youth had come from a broken home at some time in the past, which meant we provided services to 35 "step-parent" situations.

2. Information on referred offenders: In these 126 families, 138 youth had been referred as offenders (some families obviously had more than one youth about which the referring source was concerned). There were many families that had experienced difficulty with several of their adolescents which came out and was dealt with in therapy. However, we only counted the youth who were referred at the point of telephone intake. Of these referred offenders, 67 were male and 69 were female. Thirty-three of these offenders were deinstitutionalized with the help of FTI (13 from SIS, 7 from foster homes, 6 from the State Hospital, 4 from jails, 2 from group homes, and 1 from detention). Our staff evaluated each situation in terms of "high risk" or "low risk" of placement outside the home at the beginning of services; this is our best knowledge of how many of these 138 youth would very likely have been placed without family therapy intervention. Our assessment was that 36 were "low risk" and 102 were "high risk." For many in the high risk category, FTI was the last step before a court hearing to request custody removal and placement. Of this number, only 15 cases have been placed since attendance at FTI!!

Phase I was used to temporarily house 14 youth while they awaited their families' arrival. The average stay was just over 96 hours.

3. Information on services provided: A total of 339 days of service were provided to the 126 families, which averages to a 2.7 day stay per family. (This number gradually rises since we are now more adamant about a 3-day stay, but initially often accepted 2 days). A total of 721 sessions were held (an average of 5 3/4 sessions per family), and the sessions provided 1098 hours of therapy (this averages to 1½ hours per session, or 8.7 hours per family)

4. Information on referral sources: Referrals were received from 39 different sources. Thirty-six referrals were from Juvenile Courts, 42 referrals were from County Social Service offices, 12 referrals were from the State Industrial School, 9 referrals from the State Youth Authority workers, and 8 referrals came from families themselves. The rest of the referrals numbered: 5 from Area Social Service Centers, 3 from Mental Health Centers, 3 from medical facilities, 3 from attorneys, 3 from high schools, 1 from the State Hospital, 1 from a Police Department, and 1 from a Probation Officer on a reservation for Native Americans.

A total of 33 staff from the families' local service agencies attended the FTI stay with one of their families. They were provided a place to stay in Phase I or II facilities at no cost to themselves or their agency, to participate and receive training.

The information for the above statistics is compiled from the FTI log, which therapists fill out after each family (Exhibit Y, page 52). This information is kept in each file on a fact sheet (Exhibit Z, page 53).

B. Evaluation of Results

1. As seen by FTI: We hope the statistics speak to you in the same positive way they have spoken to us! Placement of 15 youth out of 138 offenders has far exceeded what we had even hoped. This is a 10.8% placement rate; the rate has consistently been between 10% and 12% throughout this 10-month period (once an adolescent is placed, he/she is always counted in this placement number, even though some of those placed have now returned home). Of these 15 placements, 4 went to foster care, 4 to group homes, 3 to chemical dependency units, 3 to SIS, and 1 to a relative's home arranged by the family. Of the 33 offenders that we deinstitutionalized, only 2 have returned to placement (both to the placement from which they came).

Although the "hard data" more clearly proves the effectiveness of the approach, it is the feedback from families and referral sources that energizes our staff and makes our schedules and our hard work so much more rewarding than previous programming.

2. As seen by the families: Each family member is asked to fill out an evaluation form (Exhibit aa, page 54 is an example) before they leave FTI. The staff receives so much positive feedback about the program design and results from families during therapy that cannot be effectively expressed here. Certain comments are heard over and over: "I didn't think it would be any good to come for only 3 days, but it seems like we've been here a month!" "We've been all over--to psychiatrists, psychologists, social workers, clergy--but this is different!" "I came here with the idea nothing would work out and we'd have to go our separate ways--I wish we'd have had this months ago!"

We have typed and included a few family evaluations (Exhibit bb, pages 55-58) We hope this will give you a feel for how families express their experience. Each family is numbered so that you can see how different members react (we did not include all members--many children write very little).

We have compiled all of the evaluations (Exhibit cc, page 59) that we received from family members (not all families wrote evaluations--sometimes families forgot, therapists forgot, some members did not fill one out, etc.) We have a total of 346 evaluations (137 adult, 209 children). With this open-ended evaluation, we tabulated what the family members chose to write about in both positive and negative ways, so that you could see what parts of the program they felt they wanted to tell us about and were worthy of mention.

We feel it is significant that 103 of 137 adults (75%) and 93 of 209 youth (44%) chose to make positive comments about the therapy itself when they could have said nothing at all or could have made only general comments. Fifty-seven adults and 64 youth made additional comments about specific goals reached ("closer family", and "sharing of feelings"). One hundred fifty family members (43% of those completing evaluation) remarked in a positive way about the staff.

On the negative side of the evaluations, only 21 of the 346 evaluators remarked that they disliked or didn't find the therapy helpful, only 4 had negative concerns about staff, but 187 evaluators found NOTHING negative about the program! In summary, most of our negative comments are in relation to beds, too cold, too hot, etc., but the families' positive remarks speak to the benefits of the program design and results!

3. As seen by referral sources and state network: The cooperation from across the state has been exceptionally encouraging. We have served families from over 42% of the counties in North Dakota, in spite of the very rural nature of our state.

We have included excerpts of some support letters from across the state (Exhibit dd, pages 60-61), which were written to assist us in a funding attempt. These letters represent support from many parts of the service network; they are written by people "at the top" who recognize the program's worth and are invested in seeing the service continue. There is an "iceberg effect" in terms of FTI support; the letters are only the tip--the part of the network that "shows." Our real support, of course, comes from the front line workers, the ones who actually work with families, and trust their families to our care by making referrals! The support of these people is also essential to our program. It is the network development accomplished by satisfied referral sources that helps us to become increasingly accepted and utilized across the state.

Several agencies need special mention here, to evaluate where we are and to look for future direction. One Juvenile Court has informally (but consistently) decided that no adolescent will be placed through its Court without the family first participating in the FTI program, unless participation is absolutely impossible (Courts have a way of providing "incentives" that make almost all things possible!). A County Social Service office is now beginning the same procedure in regard to requests for assistance in placement.

The State Youth Authority is a state agency under the Social Service Board of North Dakota, which is given custody of a number of youth who have "used their options" in the local system. SYS has previously cooperated in referrals and participated in a 3-day, FTI-sponsored workshop on family therapy. A plan is being formulated so that no child over whom they have custody will be placed without prior referral to FTI. These kinds of umbrella plans will have significant impact on the goals of the Family Therapy Institute--to deinstitutionalize and prevent the institutionalization of youth whose families deserve services in order to maintain their responsibility to care for the child.

XIII. DIRECTIONS FOR THE FUTURE

We believe that our present course had justified its continued use, and our main goal will be to continue to provide high quality family therapy services to families of troubled youth. As time and resources permit, there are areas in which we would like to expand.

We have felt the need to have more staff time and/or resources available for the maintenance of existing referral relationships throughout the state. This

staff, whom we would call community programmers, would be able to spend more in-depth time with Court or Social Service agencies, as we did in our experiment with one Court system. This would allow for greater understanding of family therapy philosophy, some local follow-up to families, and more opportunities to provide training for other professionals who are interested in using family therapy techniques in their agencies. We do believe that we have been fortunate in the excellent training we have received and we want to share this knowledge and skill with those who will use it to help families. We have developed a Family Therapy Training Workshop (Exhibit ee, page 62) which our staff present as requested. The results have been quite positive (Exhibit ff, pages 65-67) is a compilation of workshop evaluations from an FTI staff workshop). We believe very much that the future of FTI needs to include sharing our expertise with others. We also feel that the community programmers could develop links with referral sources who are not now referring nor sufficiently aware of our program.

Also, we would use the community programmers to provide more information across the state about Phase I of our program. Through this, we attempt to make law enforcement officials aware that an alternative to jailing status offenders does exist, and to encourage its utilization. Also, we would hope to increase referrals to Phase I as an alternative to placement in detention centers, since most status offenders who are placed there are responding to family dysfunction. In short, we feel that our emphasis in the first year of operation was the development of quality family therapy in Phase II, but that the time has now come for Phase I to receive the priority it could and should receive.

We are aware that a particular population of North Dakota families--the Native American families living on North Dakota's four reservations--lies yet untouched in our development of linkages. We have much work to do to learn about the Native American culture to find out in what way we could be of service to this population.

Depending on available funding, we also feel that our services could be expanded to serve families with other youth-related problems, such as delinquency and/or child abuse and neglect.

In closing, our direction will be to maintain a realistic view of what family therapy can do--it does not perform miracles, it does not promise all problems will be solved, or even that any problem can be solved completely. But we will look to a future of providing an effective way of helping a family to help itself and to stay together.

APPENDIX

Exhibits A-ff

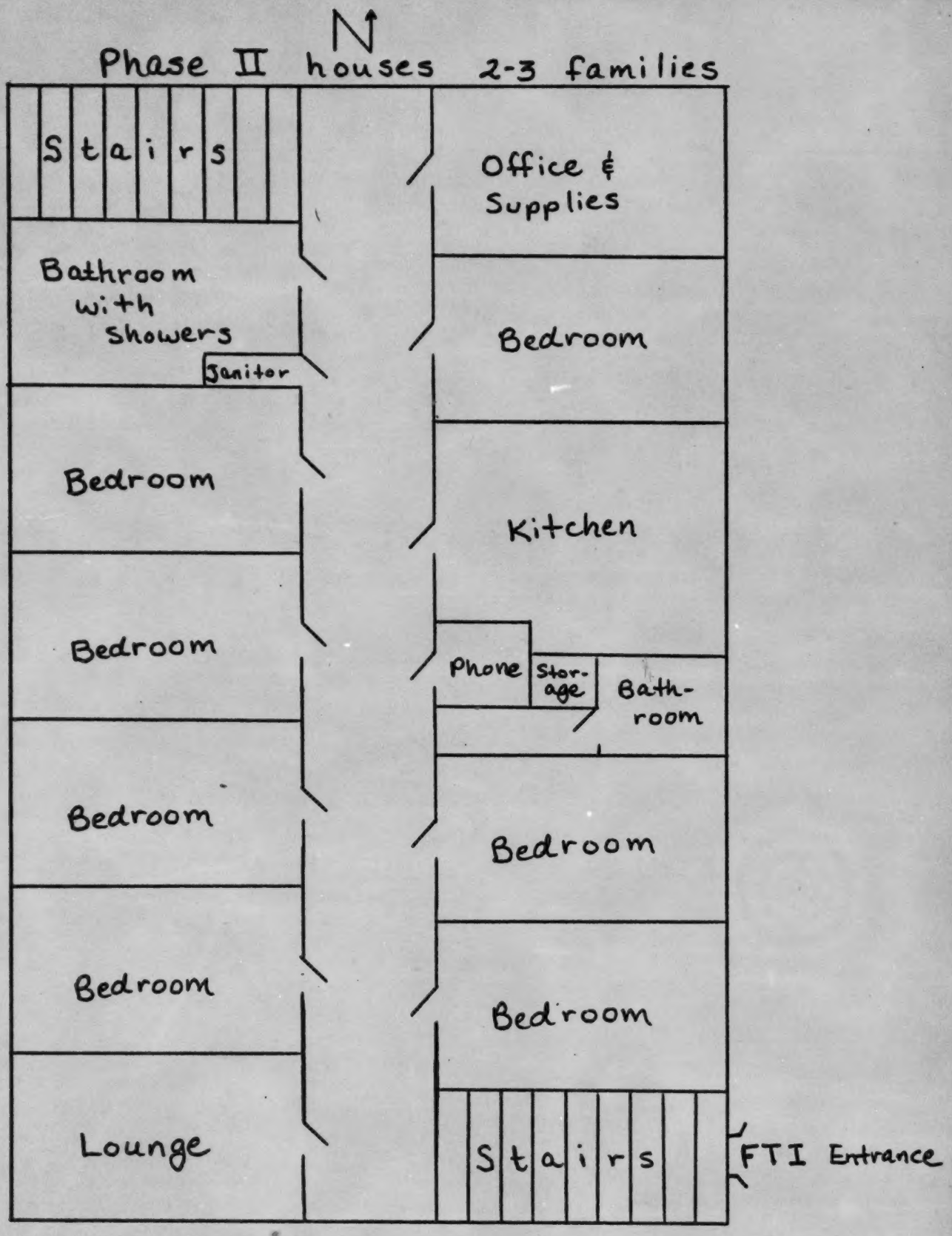


EXHIBIT A
Floor Plan of Phase II

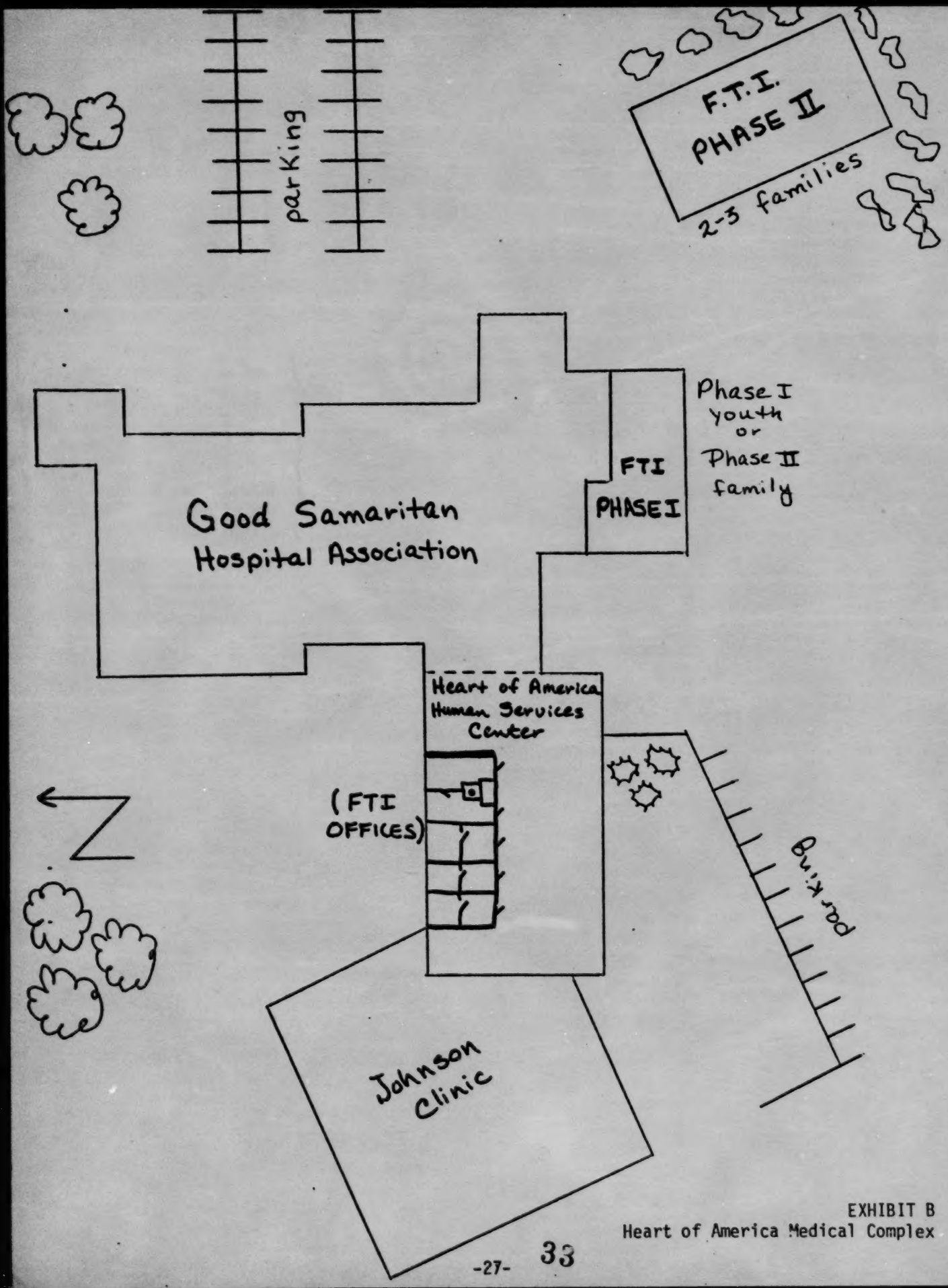


EXHIBIT B
Heart of America Medical Complex

FAMILIES ARRIVE ONLY ON SUNDAYS AND THURSDAYS SUN	MON	TUES	WED	THUR*	FRI	SAT	Super-vision by
THIS SCHEDULE IS PROVIDED TO SHOW THE REGULAR STAFFING PATTERN FOR 7-DAY-PER-WEEK PROGRAM, AND EXAMPLES OF HOW FAMILIES ARE ASSIGNED TO THE TEAM MEMBERS.				All families arrive by 10:00 p.m. *1st family* *2nd family* 3rd family 4th family	*primary team-* secondary team-	*Therapists A & B* *(Ts. A & B)* Therapists C & D (Ts. C & D)	Sup.D
All families arrive by 10:00 p.m.	9:00 STAFFING 1:00 INSERVICE	Ts. C & D off		*1st family* 2nd family 3rd family	Ts. A & B off	*Ts. C & D* Ts. E & F	Sup.G
4th family (Ts. C & D)	9:00 STAFFING 1:00 INSERVICE	Ts. E, F & G off		*1st family* *2nd family* 3rd family	Ts. C & D off	*Ts. H & F* Ts. A & G	Sup.G
	9:00 STAFFING 1:00 INSERVICE	Ts. A & G off		1st family 2nd family	Ts. H & F off	Ts. C & D	Sup.D
3rd family *4th family (Ts. A & B)*	9:00 STAFFING 1:00 INSERVICE	Ts. C & D off		*1st family* 2nd family	Ts. A & B off	*Ts. C & D* Ts. E & F	Sup.G
3rd family (Ts. C & D)	9:00 STAFFING 1:00 INSERVICE	Ts. E & F off		*1st family* *2nd family* 3rd family 4th family	Ts. C, D & G off	*Ts. E & F* Ts. A & B	Sup.G
	9:00 STAFFING 1:00 INSERVICE	Ts. A, B & G off		*1st family* *2nd family* 3rd family	Ts. E & F off	*Ts. H & B* Ts. C & G	Sup.D

The first team is the primary team for the weekend; that means that should 3 families come in for the weekend, the primary team will take 2 of them.

Therapists H & G are members of a therapy team only once per month, since their positions at FTI are Director and Program Coordinator, respectively.

EXHIBIT C
Phase II Schedule

WHY DO WE ALL HAVE TO COME?

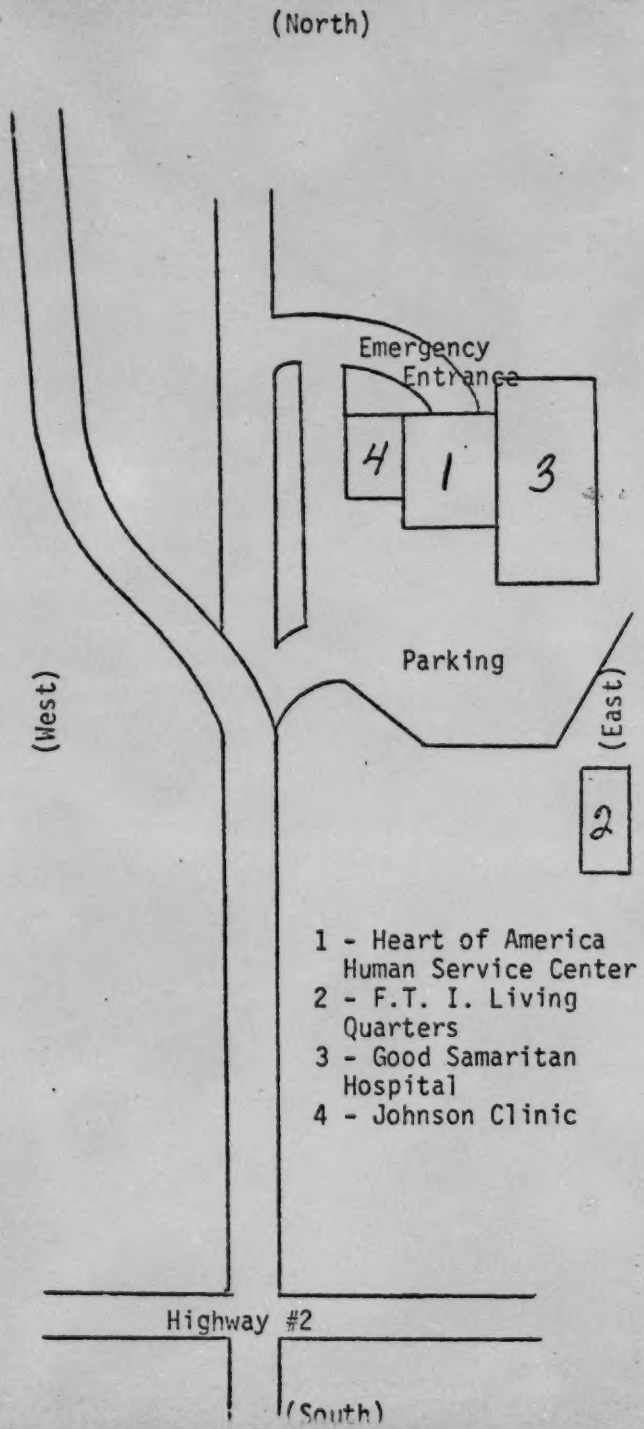
It has been our experience that the people who have lived with and loved a young person the most, are the people whose help we need to help that young person who is experiencing some sort of difficulty at this time. That's why we require your entire family to be here and aid us in providing top quality services. We realize that coming here can sometimes be scary; this is only a natural reaction when you are facing something unknown. We hope this information has made you a little more clear as to what goes on here.

FOLLOW-UP

Before you leave, our staff will talk with you about other resources that will be available to you in your local area, if you should desire further services for your family. With your permission, we would contact the person or agency who suggested you come here, and give them basic information about what you thought of your stay here.

If your family would like to return to the F.T.I. for more sessions at any future time, either to work more on the issues you came with, or to resolve new issues, you need only contact us by phone. We are glad to see familiar faces again, and to provide further help if you desire.

Because we need to know how effective our program has been, we will be gathering follow-up information after your family has visited us.



1 - Heart of America Human Service Center
2 - F.T. I. Living Quarters
3 - Good Samaritan Hospital
4 - Johnson Clinic

WELCOME TO THE FAMILY THERAPY INSTITUTE

Gary Wolsky, Director

A VIABLE ALTERNATIVE TO INSTITUTIONALIZATION OF STATUS OFFENDERS

Heart of America Human Services Center
Rugby, North Dakota
776-5751

EXHIBIT D
Family Brochure

WELCOME!!

Although the circumstances which bring your family to the Family Therapy Institute may not be all that pleasant, together we can make your visit to Rugby an agreeable and even fun learning experience. This pamphlet will introduce you to the Family Therapy Institute and help you to understand some of our procedures.

HOW TO REACH US

If your family wishes to use the services of the Family Therapy Institute, arrangements can be made either by calling us, or through the agency or person who has been helping your family.

If you arrive at the Institute between 8:00 a.m. and 5.00 p.m., Monday through Friday, come to the Human Services Center entrance (a), as drawn on the map. If you arrive after hours, or weekends, please go to the emergency entrance (b), and ask the admissions personnel to page our staff with Beeper #224. Our staff will meet you there shortly.

WHAT TO BRING

You will need to bring clothes, personal toilet articles (deodorant, shampoo, soap, towels, etc), alarm clock, and radio (if you wish).

WHEN YOU GET THERE

Once you have arrived at the F.T.I., you will be taken over to your living quarters. This building is a residence for hospital personnel, so there will be other residents staying on other floors. The floor on which F.T.I. families stay has a number of bedrooms, a kitchen area, a lounge, and shower facilities. THE KITCHEN HAS ALL THE UTENSILS NEEDED FOR PREPARING AND EATING A MEAL. Your food may be brought with you or purchased at one of the local grocery stores. Another option is to eat at our local restaurants or at the hospital cafeteria, which is right in the Human Services Center complex. Blankets and linens will be provided for you Also located on your "living quarters" floor is a pay telephone and if there is a need for people back home to get in touch with your family between sessions, the number for that phone is 775-9518.

COURTESY AGREEMENTS

Because we rent only the third floor of this building for "our" families, we ask that all family members remain on that floor. Bedtime and mealtime are left up to you and your family to decide, but we ask that if you plan to leave your living quarters in the evening, you be back by 10:00 p.m. as the door is locked from that time until 8:00 a.m. Please observe our "Quiet Hours" from 10:00 p.m. to 9:00 a.m. because the other residents on the floors below you appreciate their rest. Each family is responsible for the conduct of its members, and parents are expected to set appropriate rules for their children.

SESSIONS

After getting acquainted with your living area, a time will be set up for a family session. Two members of our staff will meet with the entire family to discuss reasons why you're here and to begin to resolve difficulties that may exist. The length of stay and the number of sessions your family has while they are here will be determined by your family, with input from our staff. The average length of stay is three days, and most families have two or three sessions per day. Our days are sometimes long and tiring for your family, because we have little time, often with much to do. We do have a young staff, and a very excited and pleasant staff, who will make you feel as comfortable as possible, and yet who will do what needs to be done to help your family.

FAMILY TIME

In between sessions there will be free time which can be spent in family discussions or taking advantage of recreational activities such as swimming (bring swimsuits), or taking in a movie. Any hobbies, crafts, or games that your family likes doing together can be brought with you to the Family Therapy Institute to be enjoyed during this free time.

COST

Your only cost will be for food and transportation. Our services are provided through a grant from the Office of Juvenile Justice and Delinquency Prevention.

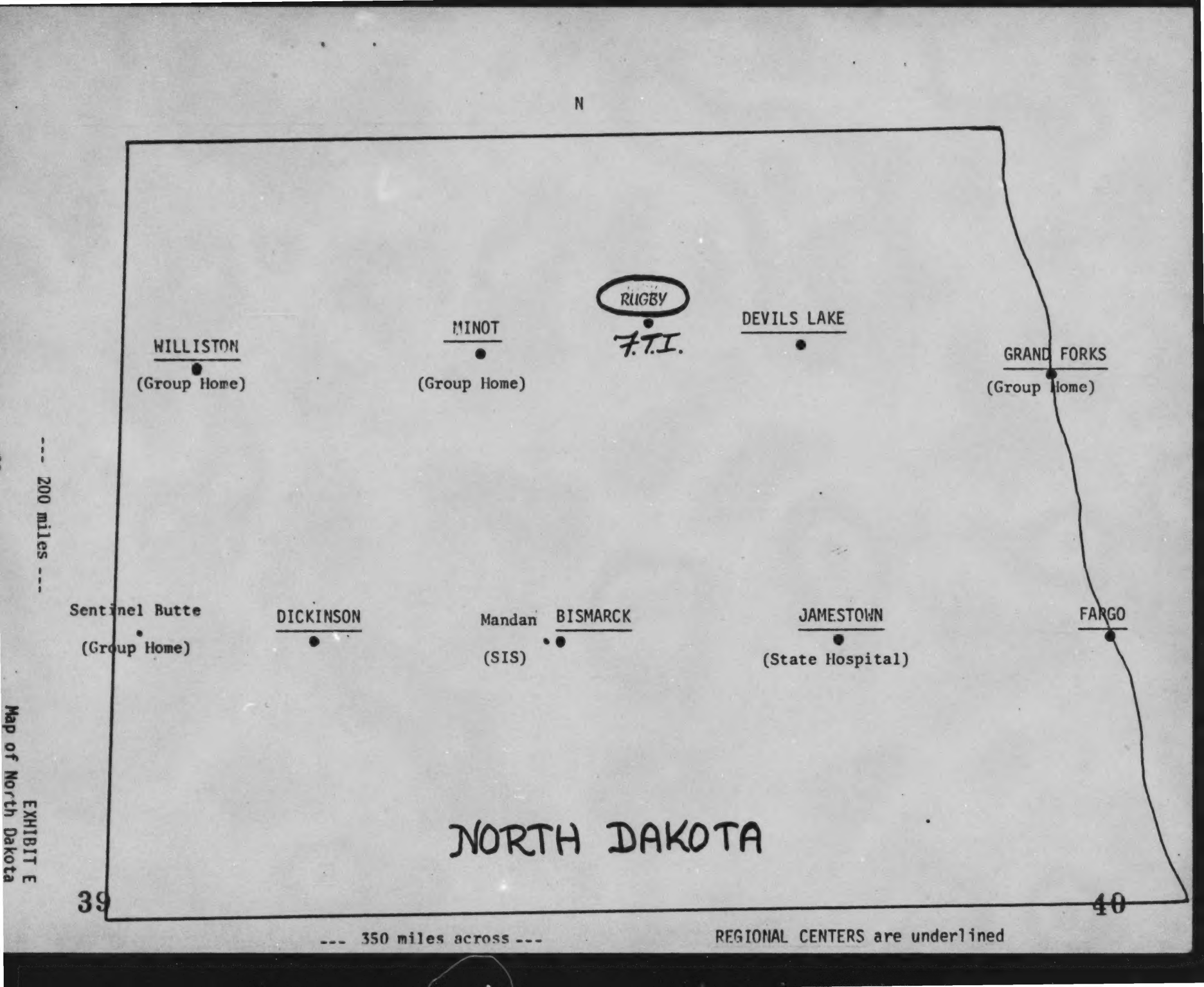


EXHIBIT E
Map of North Dakota

This mobile depicts how a particular family might be structured. A woman with 3 children from a previous marriage is now remarried and they have a child from the second marriage. The family comes to therapy because the 16-year-old is in minor trouble with the police and want to quit school.

This mobile shows the family's structure, and the processes that are seen in therapy:

(a) *The mother and her first 3 children are closely aligned.*
(b) *The 2nd husband is distant from the children of the 1st marriage, but closer to his own baby.*
(c) *Even though the 2nd husband is distant, he carries much weight in the family, and can outweigh the mother easily.*
(d) *The mother carries little weight, and since the step-father & children aren't close, she often ends up with her children between her husband and herself.*
(e) *Although a divorce has occurred, the 1st husband is still somewhat "in the picture," which keeps the children from being closer to their step-father, and stands between the 2nd husband/wife team (this would not always be so, but is a problem in this particular family, since it gets in the way of problem-solving).*

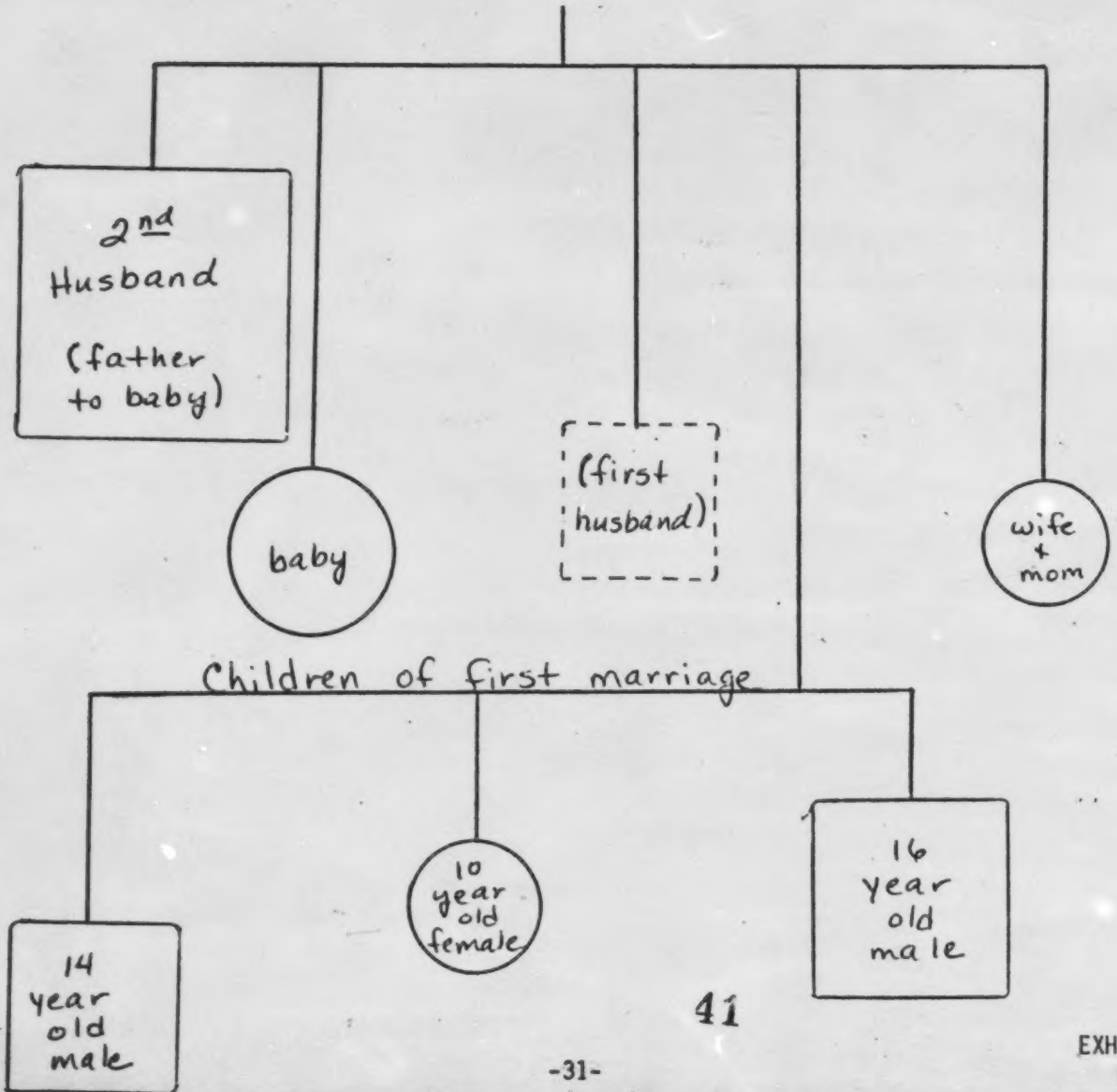


EXHIBIT F
Mobile

FAMILY THERAPY BOOKS

that we have found helpful and practical

Haley, Jay. Uncommon Therapy. W. W. Norton and Company, Inc. New York, 1973.

Haley, Jay. Problem Solving Therapy, Harper Colophon Books, New York, 1976.

Minuchen, Salvador. Families and Family Therapy. Harvard Universities Press, Cambridge, Mass. 1974.

Napier, Augustus Y., and Whitaker, Carl A. The Family Crucible. Harper and Row, New York, 1978.

Palazzoli, Mara Selvini. Paradox & Counderparadox. Jason Aronson, New York, 1978.

Skynner, Robin A.C. Systems of Family & Marital Psychotherapy. Brunner/Mazel, New York, 1976.

(This is by no means a list of all the excellent resources on family therapy. We felt it was best to point you to a few good books in the hopes you would actually seek these few out.)

EXHIBIT G
Recommended Books on Family Therapy

AUTHORIZATION FOR AUDIO-VISUAL TAPE
RECORDING AND USE THEREOF BY THE
FAMILY THERAPY INSTITUTE

I,_____, hereby authorize and permit the Family Therapy Institute, and any of its authorized professional staff or employees, to perform audio-visual recording to be used for professional supervision, therapeutic playback, and staff training and development.

I understand that continuance of services and assistance is in no way contingent upon my giving consent to such taping, and that I retain the right to withhold such consent now or at any time in the future. It is my understanding that withdrawal of consent will result in immediate termination of such taping; and that upon written request, by me or my representative, any tapes made under this agreement will be destroyed.

No fee or other compensation of any kind shall be due to me for granting the audio-visual tapes recording and/or use thereof.

I do hereby warrant that I am over the age of 18 years and have every right to contract in my own name and further that I have read the above authorization and am fully familiar with its contents.

Dated this _____day of_____19___.

_____
Client

_____
Witness

EXHIBIT H
Video Release Form

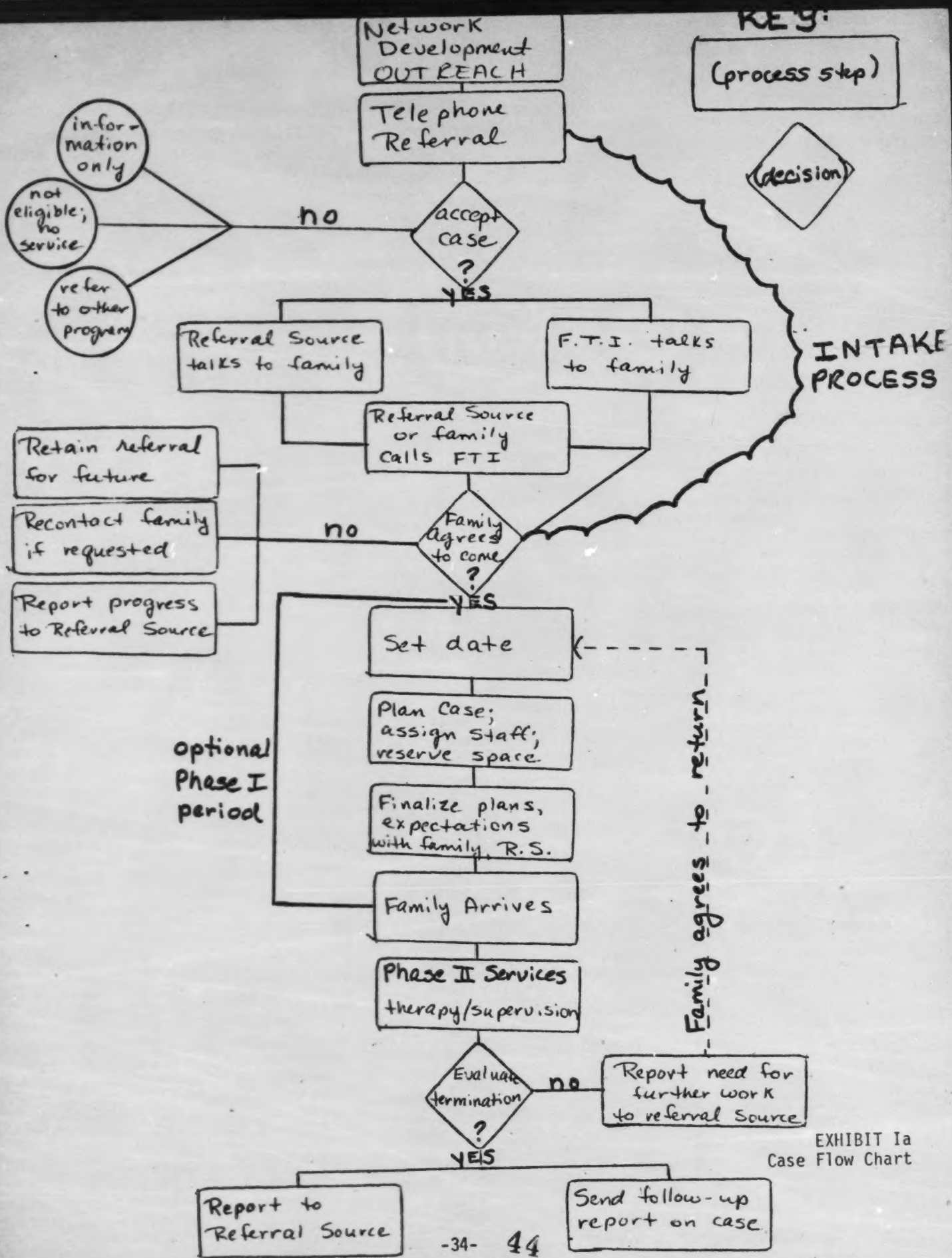


EXHIBIT Ia
Case Flow Chart

Schematic of the Family Therapy Institute Program

Referral Sources

1. Judges, juvenile supervisors, and county social workers attend workshops at Family Therapy Institute.
2. The above make appropriate referrals to the Family Therapy Institute.
3. Other sources, such as educational, religious institutions, or private individuals make referrals.
4. Once a referral is made, treatment will begin with either of the following options:
   OPTION 1: When it is deemed unworkable for the juvenile to remain in the family home or if the juvenile is not at present residing with the family, he/she will enter Phase I of the Family Therapy Institute.
   OPTION 2: A referred family may enter Phase II of the Family Therapy Institute directly without experiencing the removal of a juvenile from the home and placement into Phase I.

RUGBY

Phase I

1. Committment from juvenile's family to attend Family Therapy Institute within the following 96 hours is obtained.
2. Juvenile is accepted into Phase I of the program.
3. Juvenile undergoes intake and orientation procedures.
4. If needed, juvenile will be involved in educational testing.
5. Juvenile is presented with Phase I educational materials and lectures.
6. Juvenile awaits the arrival of his/her family to Phase II.

Phase II

1. Juvenile and his/her family live together in Family Therapy Institute for 3 days.
2. Family is involved in intense therapeutic treatment sessions.
3. Family takes part in various supervised recreational activities.
4. Family is presented with educational materials designed to strengthen communication skills.
5. Family executes general housekeeping and meal preparation activities.
6. Following completion of treatment as desired by family, an agreement for a "follow up" visit is established.
7. Family returns to community with organized support through Community Program planning.

Phase II

1. Family which has completed Phase II returns for therapeutic visit.
2. Family re-evaluates communication skills in therapy sessions.
3. Family, in therapy sessions, deals with particular problems which have arisen since Phase II treatment.
4. Family returns to community and continues involvement with local resources, as they are available, &/or desired.

EXHIBIT Ia
FTI Schematic

Family Therapy Institute

The Family Therapy Institute is available to the entire state of North Dakota to serve as an additional resource to the Juvenile Justice system, the various county social service offices, institutions, and families throughout the state. The Institute is located in and adjacent to the Human Services Center which is an integral part of the Heart of America Medical Complex, a "pilot project" for rural America offering total health care from one coordinated service system.

The Family Therapy Institute Project consists of three phases: Phase I provides a short-term shelter care facility (up to 96 hours) for youth who would otherwise be held in an institution while they await their family's arrival; Phase II provides short-term (2-5 days), intensive family therapy to entire families housed in our family living quarters; Phase III includes provisions for the family to return, for further therapy regarding the referred problem, or in the future should a crisis occur. As a part of Phase III follow-up, local staff who will be working with the family in their community are encouraged to attend and participate in all or some part of the therapy process.

The Family Therapy Institute will serve as an option available to courts as an alternative to incarceration at the time of adjudication and/ or disposition, to institutions in order to release youth currently placed, or to social service agencies and families in order to prevent probable future institutionalization or court involvement.

Who Can Be Served

Families of status offenders who are about to be institutionalized.

Families of status offenders who are experiencing an inappropriate institutionalization.

Families of status offenders who are to the point of leaving an institution.

How To Refer

Referrals can be made by calling the Family Therapy Institute (701-776-5751). No formal paperwork process will be used, in order to service crisis situations more effectively. Appropriateness of referrals will be decided on an individual case basis. Inquiries are always welcome.

Cost

The Family Therapy Institute is being funded by a grant from the Office of Juvenile Justice and Delinquency Prevention, and services will be provided at no cost to referral sources or families, except for meals while at the Institute.

EXHIBIT J
Agency Brochure

Family Therapy Institute

Rugby, North Dakota

Gary Wolsky, Director

776-5751

Located in the

Heart Of America Medical Center

Which Includes:

HEART OF AMERICA
HUMAN SERVICES CENTER
GOOD SAMARITAN HOSPITAL
JOHNSON CLINIC

A State-wide Program Offering

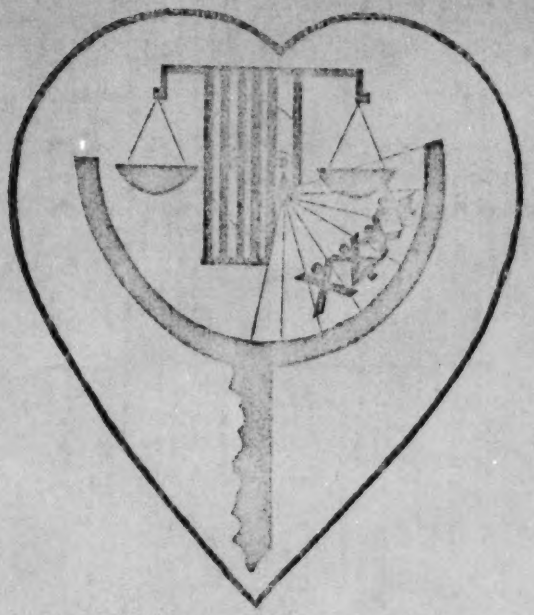
A VIABLE ALTERNATIVE TO INSTITUTIONALIZATION OF STATUS OFFENDERS

History

Since 1973, the Family Therapy Institute, previously known as the Department of Youth Services, has worked very closely with the Juvenile Court in this area. Initially, we concentrated our efforts on counseling youth who had been labeled "problem kids." We became increasingly aware of the influence of, and therefore, the need to involve families in working with troubled youth. We found that many youth eventually end up institutionalized because of a lack of resources to solve the real problem--family dysfunction.

The Juvenile Court in this district is acutely aware of the plight of youth who are labeled as a result of family circumstances totally beyond their control or the ability to understand. "Family therapy" provides us with a viable means of dealing effectively with the problem of dysfunctional families from which most of these status offenders originate. It also serves as a way of keeping families together, as well as keeping the responsibility for the care and support of juveniles with their parents where it properly belongs.

Family Therapy



A Key To The Deinstitutionalization Of Status Offenders

This new mode of treatment discards the long-held medical model of sickness and health which believes that illness lies within a particular person. The Family Therapy Institute views "problem kids" as family members who, by running away from home or performing various "acting out" behaviors, are really asking for someone to take a good, hard look at their troubled families and teach them how to achieve effective and healthy family functioning again. We deal with the family's problem, of which the status offender has become a "symptom bearer," and treat the process of interaction between the family members. By sitting down with status offenders and their families in therapy, we can get at the actual cause of the youth's behavior and produce changes in the family to alleviate the problem, thereby preventing the need for inappropriate institutionalization.

Goals

It is the belief of the Family Therapy Institute that state institutions provide a necessary function for people who can benefit most by being placed in them, but we are also aware of the fact that they should not be viewed as "catch alls" for certain young people whose problems can better be dealt with by services such as the Family Therapy Institute offers. Our prominent goal is the deinstitutionalization of status offenders who can be helped by family therapy, which eventually will lead to a more effective and less costly use of the institutions which now exist in North Dakota.

Deinstitutionalization Includes:

1) Preventing the imminent institutionalization of status offenders
2) Removing status offenders from jails and detention centers
3) Taking status offenders out of foster homes, group homes, and private hospitals
4) Facilitating the early release of status offenders from state institutions, such as the Jamestown State Hospital and the State Industrial School.

Status Offenders Include:

Anyone under 18 years of age, who has committed an offense which would not be considered a crime if committed by an adult. Examples of status offenses are running away, truancy, possession or purchase of alcohol, ungovernable behavior, and others. Status offenders are commonly referred to as "unruly children."

REFERRAL SHEET

Family Name_____ Arriving_____
Family Phone_____ Work_____ Leaving_____
Family Address_____ Date of Referral_____
_____

1. Referral Source_____ Phone #_____

   Agency_____ Plan to come ____Yes ____No

2. Identified Client_____ Age_____

3. Presenting Situation:
   ☐ Truancy ☐ Runaway ☐ Out of Parents' Control
   ☐ Curfew Violation ☐ Minor In Possession
   ☐ Suicide Threat or attempt ☐ Pregnancy
   EXPLAIN:

   Probation Offense:
   ☐ Status ☐ delinquent
   EXPLAIN:

4. Previous Services/Involvement:
   ☐ Juvenile Court ☐ SYA ☐ Social Services
   EXPLAIN:

5. Current Status:
   ☐ At home ☐ Detention Center ☐ Jail ☐ At Home-likely to be placed soon

6. Family Composition and Present Location:
   Father_____ Step-father_____
   Mother_____ Step-Mother_____

Children's Names and Ages	Family Members Coming
Ic_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Sent Brochure____ Tentative____ Confirmed____

Date:
☐ Notified Referral Source of Confirmed Dates
☐ Wait for call from Referral Source/Family
☐ Call family & when!

EXHIBIT K
Referral Sheet

REFERRAL LOG

DATE	FAMILY NAME	OFFENSE	TAKEN BY	PERSON CALLING	AGENCY	1 mo.	2 mo.	3 mo.	COMMENTS:

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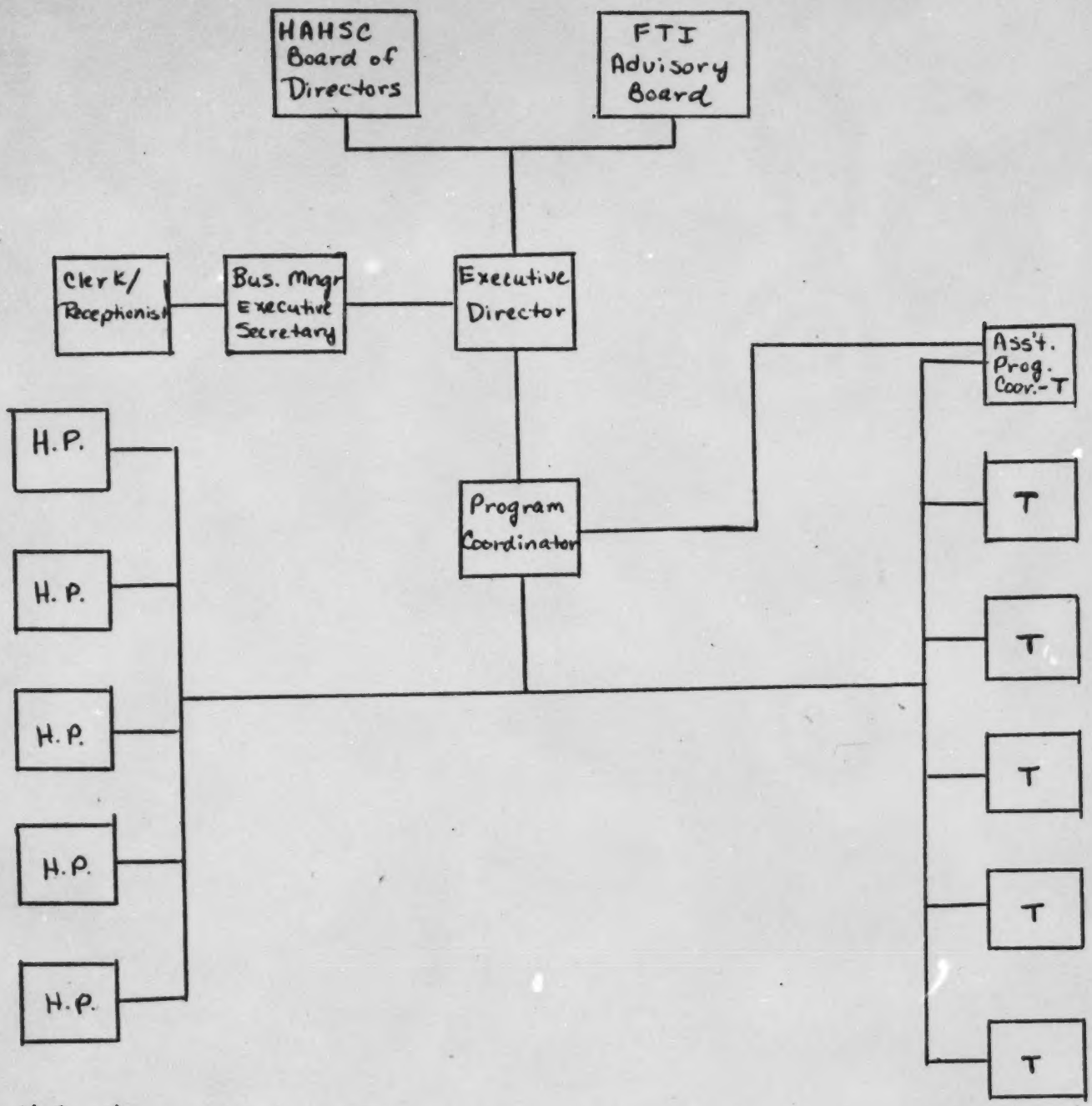
EXHIBIT L
Referral Log



H.P. = Houseparent
Phase I

T = Therapist
Phase II

EXHIBIT M
Staff Flow Chart

IX A

BUDGET

12 Month Period
1978-79

PERSONNEL			$161,006
FRINGE BENEFITS (15.08% of Personnel)			24,280
CONTRACTUAL			13,747
RENT			
Phase I (1100 sq ft. @ $3.15 sq ft.)	3,465		
Phase II (2232 sq ft. @ $5.00 sq ft.)	11,160		
Office (1418 sq ft. @ $6.50 sq ft.)	9,217		
Workshop Related	250		24,092
TELEPHONE AND SUPPLIES			
Telephone: Local (14 phones @ $15/mo - $210 x 12)	2,520		
Long Distance ($250/mo avenrage)	3,005	5,525	
Photocopying		820	
Meals (based on $1.75 average/meal for Phase I cleints)		2,211	
Postage		965	
Office Supplies		1,278	
Training Material, Books, Publications		1,770	
Miscellaneous (hygiene kits, recreation)		1,125	13,694
TRAVEL			20,242
EQUIPMENT			6,670
TOTAL ----			$263,731

EXHIBIT N
Budget

Phase I: Shelter Care for Youth; or Phase II: for One Family
(Accessible to handicapped)

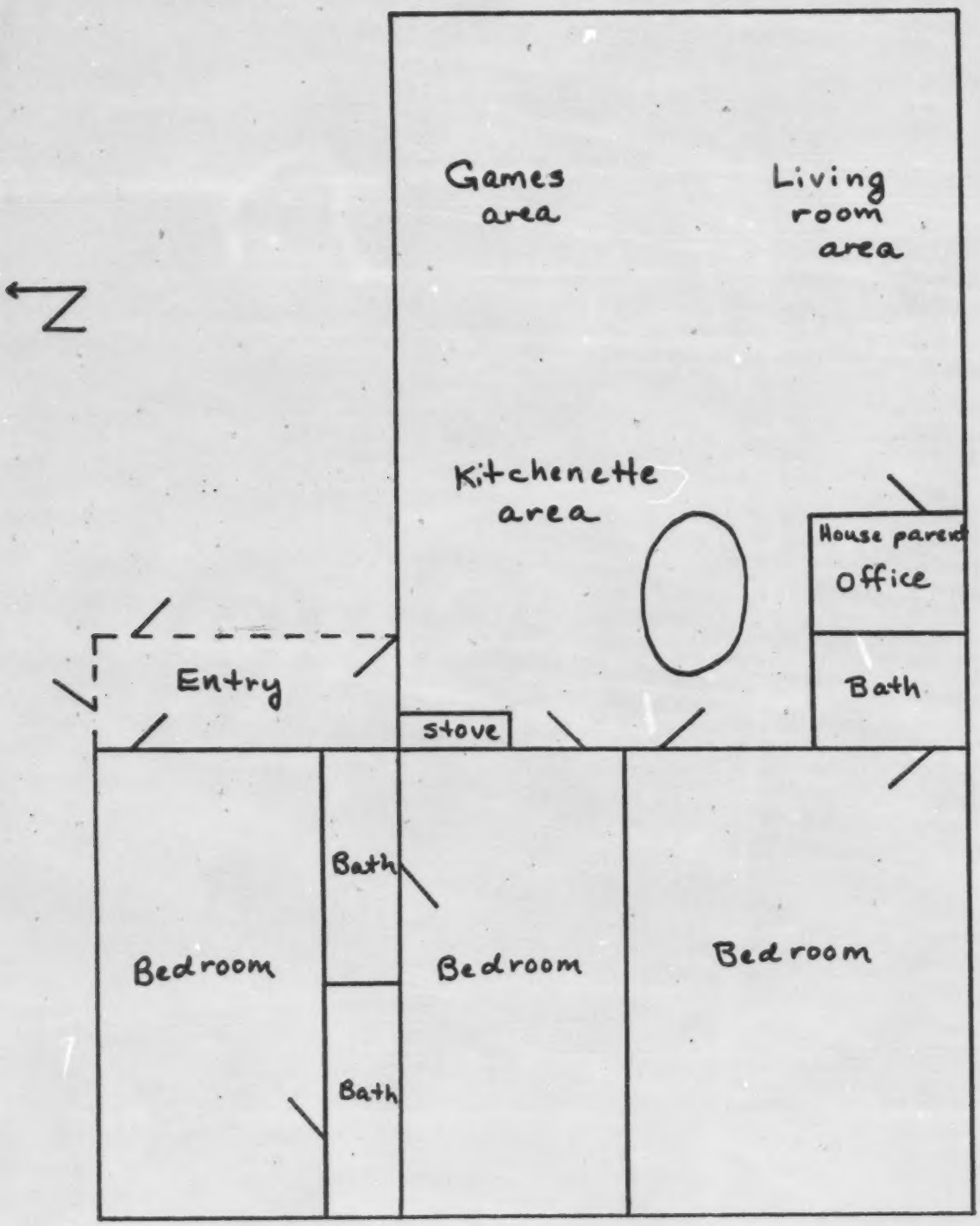


EXHIBIT O
Floor Plan of Phase I

INFORMATION FOR HOUSEPARENTS

Client's name, age, sex

Where they are from

Why placed

Initial reaction to being placed in facility

Rules

Background

Family Composition

Emotional make-up (temperment, drugs, suicide, incest)

Specific behavioral problems

Ways to handle behavioral problems

What should talk about, avoid, do, what to watch for

How long stay

Case manager

Case plan

EXHIBIT P
Information for Houseparents

Other agencies involved

CASE MANAGER'S RESPONSIBILITIES

1. Notify houseparent of impending arrival - give basic information
2. Call back houseparent when time of arrival is determined - give any further information and any known special needs; notify Betty of client's arrival
3. Meet with client prior to going to facility to assess strengths, weaknesses
4. List rules for client and necessary information in yellow sheet*
5. Be present at beginning of each houseparent shift. When not possible, call houseparent with specific directions.
6. Keep houseparent informed of any emotional changes, impending crises, etc., through phone calls (if immediate), or through entries in yellow sheets*
7. Notify houseparent of plans, or change in plans through yellow sheets*
8. Notify Betty when client leaves

*Personal visits to relay information are <u>always</u> welcome, but please be sure you <u>also</u> enter all information on yellow sheets.

Date:_____

Time:_____

Social Worker:_____

CLIENT:

1. *Phone calls:*

   Are they allowed?

   to who

   from who
   (length)

2. *Visits:*

   Are they allowed

   who can visit

   for how long

   when can the visit take place

   can client go outside the facility with visitor without houseparent present

3. *Special rules:*

   A change of any set rule(s)

EXHIBIT Q
Individual Privileges

DATE_____

DEPARTMENT OF YOUTH SERVICES INTAKE FORM

ame Last	First	Middle

ate of Birth	Place of Birth	City of Residence Street State

ive Your:
Exact Height (in shoes) _____ft. _____inches
Accurate Weight (in ordinary clothes)_____lbs.

. Are you now in good health as far as you know and believe? (If other than "Yes", give details)

. Are you presently under a physicians care? ____YES ____NO
If "Yes", Doctor's name_____
(Clinic) Address_____
Phone Number_____

. Are you presently taking any medications? _____YES _____NO
If "Yes", name of medication_____
Prescription? _____YES _____NO

. Do you feel you are in need of treatment for alcohol or drug dependence? ____YES _____NO

. Are you sensitive to any medications to your knowledge? _____YES _____NO

. Do you have any known allergies? _____YES _____NO

. Have you ever had, consulted or been treated by a physician or other person for any of the following: (Answer "YES" or "NO" to each. If "YES" give full particulars in space below)

emia		Disease of Urinary Bladder		Kidney Disease		Peptic Ulcer	
pendicitis				Liver or Gall Bladder Trouble		Pleurisy	
thma		Disorder of Stomach or Intestines		Meningitis		Rheumatic Fever	
ncer or Tumor		Epilepsy		Mental or Emotional Disorder		Rheumatism	
ronic Cough, or Blood Spitting		Goitre		Nervous Disorder		Scarlet Fever	
nvulsions		Heart Trouble		Other Blood Disorder		Severe Headaches	
abetes		High Blood Pressure		Other Lung Disorder		Surgical Operation	
scharge from Ear		Indigestion		Paralysis		Syphilis	
						Tuberculosis	

Signature_____ Date_____ Official_____

EXHIBIT R
Medical Intake Form

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FTI (11/78) THE 10 COMMANDMENTS OF FACILITY LIFE

1. I AM YOUR FACILITY - THOU SHALT RESPECT ME

   (Translation: Keep the joint clean, be careful with your lighted cigs, keep the stereo and TV at a civilized noise level, etc.)

2. THOU SHALT NOT TAKE THE NAME OR STATE OF ANYONE IN THIS PLACE IN A DISRESPECTFUL MANNER

   (Translation: Everyone here has an equal right to be respected. Since everyone is different, try to keep your differences from annoying others!)

3. HONOR THY HOUSEPARENT AND THY SOCIAL WORKER

   (Translation: They didn't put you here - so long as we're all stuck together, be cooperative with supervisory and counseling activities. Don't forget, the "horn" is the responsibility of the houseparent.)

4. REMEMBER TO KEEP HOLY YOUR SCHEDULE

   (Translation: Get to bed at a decent hour and be up before the day is shot - be ready for educational and recreational activities.)

5. THOU SHALT NOT KILL THYSELF (OR ANYONE ELSE FOR THAT MATTER)

   (Translation: Need I say more?!)

6. THOU SHALT NOT COMMIT OBNOXIOUSNESS

   (Translation: For instance - bragging, flaunting, boring grossities, etc.)

7. THOU SHALT NOT STEAL AWAY

   (Translation: Those who run away are run after by the police.)

8. THOU SHALT NOT BEAR FALSE WITNESS AGAINST THY NEIGHBOR

   (Translation: This means not bitching constantly about other kids, and your family, too.)

9. THOU SHALT NOT COVET THY NEIGHBOR'S SITUATION

   (Translation: You aren't from the same family; don't whine about why you aren't getting exactly the same treatment.)

10. THOU SHALT NOT FORCE US TO MAKE ANOTHER COMMANDMENT

    (Whew!)

EXHIBIT Sa
Phase I Rules: Youth Copy

PHASE I RULES

1. *Phone*

   No calls IN or OUT unless the social worker has given permission in the yellow sheets (this includes parents' calls).

2. *Bedtime*

   Weekdays - no later than midnight
   Weekends - no later than 1:30 a.m.

3. *Supervision*

   Client must be accompanied at all times, including to cafeteria and vending room. Houseparent will accompany client to and from offices for appointments; if there are several clients, the social worker should come and get and return client.

4. *Visits*

   Same procedure as phone calls.

5. *Lending*

   No staff will lend money. If money is needed, should be from FTI fund.

6. *Meals*

   Houseparents will discourage wasteful habits (excessive food, uneaten sandwiches, "salad and milk" meals).

7. *Cigarettes*

   Staff should NOT get cigarettes for clients. They must walk and purchase their own.

8. *Smoking*

   No smoking in any bedrooms at any time.

9. *Room Assignment*

   When possible, S.O.P. will be to place clients in separate rooms, regardless of request to stay together.

EXHIBIT Sb
Phase I Rules: Posted Copy

FACILITY LOG

CLIENT NAME _____ PRIMARY CASE MANAGER _____

Blue Ink - Routine
Green Ink - All Houseparents Read
Red Ink - All SW Staff - Attnl action requested

SECONDARY CASE MANAGER _____

Shift or Time	Staff Member	Remarks

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EXHIBIT T
Houseparent Log

SCHEDULE FOR 5 HOUSEPARENTS - PHASE I

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
					1 2 3	1 2 3
4 5 1	4 2 3	2 5 1	4 5 3	5 3 1	4 5 1	4 5 1
2 3 4	2 5 1	5 3 4	2 3 1	5 1 4	2 3 4	2 3 4
5 1 2	5 3 4	3 1 2	5 1 4	3 4 2	5 1 2	5 1 2
3 4 5	3 1 2	1 4 5	3 4 2	1 2 5	3 4 5	3 4 5
1 2 3	1 4 5	4 2 3	1 2 5	4 5 3	1 2 3	1 2 3

The shifts run 8:00 a.m.-3:00 p.m.
3:00 p.m.-10:00 p.m.
10:00 p.m.-8:00 a.m.

This schedule repeats itself every 6 weeks. The schedule provides for 18 working days per month. Houseparents were expected to attend all Monday F.T.I. staffings and any appropriate in-service, in addition to their scheduled hours. This schedule was developed to meet 2 personnel scheduling priorities: 1) to provide for one long weekend OFF every three weeks, and 2) to maintain the same shift for a period of time, with days off between changes in time of shifts, to readjust sleeping schedules, etc.

When Phase I was unoccupied, houseparents could remain in their homes "on call". During their shifts, they were also called upon to accompany families to F.T.I. recreational activities, such as swimming, when an F.T.I. staff member had to be present.

EXHIBIT U
Houseparent Schedule

HEART OF AMERICA HUMAN SERVICES CENTER, INC.

Rugby, North Dakota

RELEASE OF INFORMATION

_____
(Name and Age - Parents or guardian)

authorize(s) the exchange of information between the Heart of America Human Services Center and the following person(s) and/or Agencies:

_____ _____
(Staff Signature) (Applicant's Signature)

_____
Date

EXHIBIT V
Release of Information Form

Family Therapy Institute

HEART OF AMERICA HUMAN SERVICES CENTER
RUGBY, NORTH DAKOTA 58368

TELEPHONE: 776-5751
GARY WOLSKY - DIRECTOR

ASSESSMENT OF INTERVENTION

FAMILY NAME

THERAPISTS

REFERRAL SOURCE

SESSIONS

FAMILY MEMBERS PRESENT

PRESENTING PROBLEM

GOALS

FAMILY DECISIONS

ASSESSMENT OF INTERVENTION

FOLLOW-UP

EXHIBIT W
Outline of Written Report

Contact Sheet

DATE	T. INIT.	CONTACT PERSON	SITUATION

EXHIBIT X
Contact Sheet

TI 9-79)

FTI LOG

Date In	Date Out	Offense	Family Names & Ages	Referral Source (*attend)	County	T.H.	# Ses. Hrs.	Ph. I X	BH SP	Low o High Risk	D S O Where?	Placed Where When?
	67											

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EXHIBIT Y
FTI Log

FACT SHEET

FAMILY NAME_____ DATE OF REFERRAL __/__/__

STATUS OFFENDER_____ AGE____

RACE: Caucasian ____ SEX: Male ____
Oriental ____ Female ____
Native American ____
Black ____
Latino ____

FATHER_____ SIBLINGS_____ AGE____

MOTHER_____ _____ ____

STEP-PARENTS_____ _____ ____

ADDRESS_____ _____ ____

_____ _____ ____

PHONE #_____ _____ ____

PHASE I:

Date In __/__/__ S M T W T F S Date Out __/__/__ S M T W T F S

Time In _____ Time Out _____

PHASE II:

Date In __/__/__ S M T W T F S Date Out __/__/__ S M T W T F S

Time In _____ Time Out _____

REFERRAL SOURCE:

Juvenile Supervisor ____
Law Enforcement ____
Social Agency ____
School ____
Parent ____
Other ____

_____ / _____ / _____
Name *Address* *Phone #*

*Reason for Referral*_____

_____

_____

_____

_____

_____

_____

_____

*PRIOR RECORD*_____

_____

_____

_____

 # OF SESSIONS ____
 # VIDEO-TAPED ____
TOTAL TIME SPEND ____

_____

_____

_____

_____

_____

EXHIBIT Z
Fact Sheet

What were the things you liked or found helpful during your stay here?

I found out that I could if I Tried to be more authoritive and not leave it up to the Judge.

I know now that I will have full Support in decision making.

Have a nice break. Good Luck with your programs.

Have a nice Holidays.

I think ours will be more enjoyable and relaxing.

Thank You,

mom

What were the things you didn't like or that weren't helpful during your stay here?

Nothing

The following are samples of evaluation forms filled out by families, following their FTI experience. Each family is numbered, so that you can see how various members responded to the same experience. Each evaluation is quoted in its entirety.

WHAT WERE THE THINGS YOU LIKED OR FOUND HELPFUL DURING YOUR STAY HERE?	WHAT WERE THE THINGS YOU DIDN"T LIKE OR WEREN'T HELPFUL DURING YOUR STAY HERE?
FAMILY #1	
Mother - age 42 "What I liked the most was the counselors were very friendly and made us feel at home, even accepting the baby in the sessions also I like the man and woman team. I think that was most helpful to all family members cause if you couldn't relate to one the other came in handy. All in all I'm very happy that we decided to come down here - I feel very strongly that these sessions will bring good results."	Mother - age 42 "There was only one thing that I didn't like too well and that was our living quarters, I liked the place and everything but the girls downstairs played their stero so loud at times it woke the baby and disturbed our concentration."
Step-father "I liked the peace and quiet. I liked the idea of just getting out of town and the rat race. I especially liked the people up here and the way they helped us get back together again."	Step-father "The only thing that I can think of is when we first arrived here and we met the counselor's I felt they were too young and could not of had the experience with children to know what it was like especially teenagers. After going through this program I found out I was wrong and found both counselor's Barb & Bert to be very helpful."
FAMILY #2	
Mother "Beginning at from the time phone contact was made - the helpfulness and caring your staff gave was very evident - it was grand to work with fun caring people who were also incredibly talented and efficient. We feel inrided and enabled - and have the verbalization of continued support - How meaningful it was is also evidence by our feeling so concerned that several other families should "hurry and get here" this may or may not work."	Mother "nil"
Father 1) the personalities at Deb & Burt were protacts of the kind of caring and loving they are trying to lead us to. 2) Their techniques were good as evidenced by the results. 3) Our daughter said "I'm sure	Father None: Physical things that might make some "initial" people more comfortable- 1) new bathtub 2) fan for cooking stove 3) table lamps to read in bed by

LIKED	DISLIKED
Father continued glad we came here "even though enroute here she said "this trip is not going to change things" (I type better than I write.)	

FAMILY #3

Mother Learning to communicate better with my husband setting ground rules for the boys, together, and sticking to them. I didn't realize the barrier that was between us - as I do now, and I learned how to deal with that barrier - and will succeed! The cooperation of the entire staff was fnatastic - the friendliness, and understanding - not giving us the answers, but helping us find them ourselves. Leaning to say NO and mean no - with our having to explain myself. I believe that these sessions has brought my husband and I closer - by the means of being able to talk to one another better, or having a clearer understanding of each other. We appreciate the activities that were available to us - swimming, etc. So that our free time in new surroundings was utilized - and I feel fortunate in being able to participate in the sessions with Jody - Thank you.	Mother More private living quarters -but under the circumstances - I am aware of these reasons and thoroughly appreciate them!
Father The living quarters though somewhat inadequate were properly located for the sessions. The sessions helped me realize what the problems were that our family has. It gave me directions to follow. We were always at ease even though we agreed to sit in on the workshop. This is because of the proper leadership of Jody Cox. It was nice that FTI can allow the family to utilize the local pool. Our special thanks to the Motel Staff! Our family came her for guidance and we leave here with ideas and direction. I'm looking forward to our return trip in the last week of September. Thank you! Thanks for the setting, It helped!	Father Living quarters. I realize the staff would like to improve the quarters but the funding is the problem as it is in almost all of our lives. If each room could at least equal the standards of the T.V. room a lot would have been accomplished.

LIKED	DISLIKED
FAMILY #3 CONTINUED	
Status Offender (male, age 17) The things I found helpful was when Jody kept us out of the conversations that went on, It was frustrating at first but after you realize what was going on, Its not so bad. I think Jody was really great in what she did or attempted to do, I don't know which one yet. I thank the staff and Jody for helping me and my family deal with these problems. Sincerely,	Status Offender (male, age 17) There really wasn't anything I didn't like in end result, Thanks again!
Brother (age 15) What I found helpfull is that we all can work our problemes out togather. and with the help of all of you are problems are solved. if not Ill see you in a mornth thank you thank you Jody Cox and others.	Brother (age 15) X
FAMILY #4	
Mother - age 51 I liked being the only family working with the two counselors. And I loved the counselors who worked c us. (Barb & Gerri) They were fantastic. I hope we can work with them again.	Mother - age 51
Father - age 52 I was impressed immediately upon arrival by the action & courtesies extended to us especially by getting us special quarters with no hassle. The professionalism displayed @ the onset of our first meeting really took my by surprise I have attended forms (similar) of Therapy (family) previously & felt we accomplished more in one hour here than in 3-5 days of The other. The turnabout of our son's attitudes & behavior that occurred here, I thought would never happen. They had the ability to "see" right straight thru a problem & pinpoint it. Barb & Jerry are a couple of aces in my Book.	Father - age 52

EXHIBIT bb

FAMILY #5

LIKED	DISLIKED
Mother The talk sessions: It was about time for us to sit down and tell each other how we felt, without anyone getting upset or hyper, it showed my that we can sit down and open up with one another, which is want we should have done along time ago; but will definitely start doing this more aften in the home. Children are human beings, it's about time I realized that. My daughter surprised me, she helped me open my eyes w/ my 2 sons. Will need to work on that just as hard as my working on thying to succeed at my job--if you know what I mean! Thank-you.	Mother Can not think of a thing that was not felpful--wished our other son could have been here w/ us all.
Father I found out it is better to be more open to each other. And find out other feeling are. and give me the feeling to be close to gether and to under stand more. and over all it was very helpful. and thank you all very much.	Father There was noting that wasn't helpful. and you people are very good and helpful.
Status Offender (male, age 16) Well everybody will start to try and help one and other.	Status Offender (male, age 16) I can't really find nothing except my butt got sore.
Sister (age 16) Linda was a very helpful person - And got our family on the right foot. And put a lot of new adventures on the road to hapiness. in our household. And I liked playing corquet. with the family members.	Sister (age 16) Some of the sessions were to long. Oh I think the doors should be locked later.
Brother (age 10) I got 2 free can of Pop out of the Pop machine. It was nice to be with my brother. I liked playing croquet with my Mom & Dad & sister & brother.	Brother (age 10) Nothing.

EXHIBIT bb

COMPILATION OF FAMILY EVALUATIONS

Liked or was helpful	Adults	Children	Disliked or wasn't helpful	Adults	Children
FTI Staff	83	67	FTI Staff	1	3
Physical setting of therapy	33	26	Physical Setting	4	11
Dorm atmosphere	9	17	Dorm Atmosphere	7	14
Therapy Itself	103	93	Therapy	5	16
Closer Family	29	32	Long Meetings	1	19
Sharing of Feelings	28	32	Sharing of feelings	1	6
Rugby Location	4	3	Rugby Location	3	8
Organization of day	9	3	Organization of day	8	12
Activities (Swimming etc.)	12	67	Activities		3
Everything was helpful	2	19	Nothing I disliked or wasn't helpful	95	92

EXHIBIT cc
Compilation of Evaluations

LETTERS OF SUPPORT
Excerpts

Arthur A. Link, Governor, State of North Dakota:

...After carefully reviewing the progress and past impact of this program, I am convinced that North Dakota is very much in need of this type of programming to offer a viable alternative for youth and families in trouble. North Dakota in FY '77, spent in excess of 1.25 million dollars for foster care alone. Fragmentation of large families in many cases could be avoided with programs such as the FTI...

William A. Neumann, District Judge, Second Judicial District

...I have long been interested in the problems of young people in North Dakota. I am particularly excited about this resource which includes the provision of services to the entire family of the young person in trouble. In my opinion, the Family Therapy Institute offers a fresh and very promising approach to the problems presented to the Juvenile Court...

Dennis E. Goetz, Administrator, State Youth Authority

...The Family Therapy Institute at Rugby has provided a long overdue resource to our field staff who have become overwhelmed with large case loads and encounter many negative influences that affect their clients. The model of family therapy available through the Family Therapy Institute has allowed us to temporarily displace the family into a new environment for a concentrated examination of themselves. Staff of that Institute have proven capable of turning many of these families around precluding the removal of the child from his or her own home.

Frank J. Hager, Juvenile Supervisor, Northeast Judicial District

...I can only relate to the effect that Family Therapy has had in all but eliminating the status offender cases being referred to the Juvenile Court in this area, but I am certain it must have a favorable impact in the other areas of the State as well...

It would be difficult to put a cost savings figure on this program after being in operation such a short time but a considerable savings has resulted by keeping families together rather than using foster homes, group homes or State institutions. There are many runaways, truants, incorrigibles and the like that are in their homes and local communities that might otherwise have resulted in a custody change, and it not been for Family Therapy...

EXHIBIT dd
Letters of Support

Norman J. Backes, District Judge, East-Central Judicial District

...To my knowledge it is the only program available in the area that works directly with the family concept and although the program as initiated at Rugby has yet to achieve its ultimate potential, the services are unique in that the concept of family is emphasized and has resulted in this District of a reduction in the institutionalization of children...

Ronald H. McLean, Attorney at Law

We had the opportunity in June, 1979, to advise a family we represented that they should seek family counseling at the Family Therapy Institute in Rugby, North Dakota. The family had come to our office to represent them in an incorrigibility action they were bringing against their 13 year old son. The family was in a desperate situation. The mother was an alcoholic who also suffered from multiple sclerosis. The father owned his own business and was on the road a majority of the time. The daughter who is age 17 is getting married to escape the situation of the family. In the family there is also a 13 year old son who had raped his mother two weeks earlier. The 13 year old boy was also involved earlier with juvenile court regarding possession of marijuana. Communication was completely broken down in the family and there seemed no way that the family could ever be united again...

I can recommend the family Therapy Institute without hesitation as a place to send families at times of conflict. Certainly the family I represented was in as desperate a situation as a family can get.

Keith L. Engbrecht, Director, Employment Development Division, North Dakota Employment Security Bureau

...It is my sincere conviction that this program is a vital part of a new trend toward services to people with problems. This trend is one which brings those services to the people in their home environment. We need to support this movement and ensure that programs of this nature do not die...

TWO-DAY
FAMILY THERAPY WORKSHOP
OUTLINE

I. *Family Therapy*

A. *Why Family Therapy?*

1. *History of DYS*

2. *FTI*

3. *Families can help most*

4. *Family systems (homeostasis) - VIDEO TAPE*

5. *Patterns of interaction repeated are STRUCTURE*

B. *Who is responsible?*

1. *Family must decide on problem*

2. *Multi-problem families' many problems*

3. *Parents are ultimately responsible*

a. *What do you want?*

b. *What will you do to get it?*

c. *What's the bottom line?*

C. *Structural Family Therapy*

1. *What is a functional family?*

2. *Mapping-diagnosis (plan) - ROLE PLAY*

a. *Who has power?*

b. *Mapping the therapist*

3. *Who is "family?" - CASE EXAMPLES*

a. *Always see everyone*

II. *Techniques*

A. *Tunnel vision - FOCUS, FOCUS, FOCUS*

B. *Don't be helpful*

1. *Exacerbate behavior*

2. *Raise level of stress*

EXHIBIT ee
Family Therapy Workshop Outline

C. Don't be child-savers

1. Don't parent or side with kids

D. Restate in positive terms

1. Have a positive attitude about families

E. Use of map

1. Knowledge of power

2. Triangulation, alliance

F. Use of self

1. Personal experience

2. Forget what you learned - SAY IT!

3. Don't be a "social worker"

4. Think simple

G. Joining

1. Pacing

2. Language

3. Be positive about strengths in family

H. Paradoxical intervention

1. Backward motivation

2. Illogical extreme

I. Relabeling

1. Sick to bad

J. Sculpture - VIDEOTAPE

K. Family drawing - SMALL GROUP EXPERIENCE

L. Doubling, role playing, empty chair

M. DO, don't just talk

1. New experiences, not new insights

N. Family rules or shared assumptions

O. Content versus process

1. Blaming

2. Indecision

P. "RESISTANCE"

1. Critical of therapist to save family system

2. Critical of therapy to maintain structure

III. Live family session

A. Therapy

B. Discussion

IV. Wrap-up

A. Questions

B. Resources for further training

1. In-state

2. Out-of-state

3. Printed hand-outs and recommended books

(Each participant filled out a "Family Evaluation" form; each evaluator is numbered so that you can see the positive & negative comments regarding the workshop.)

--WHAT WERE THE THINGS YOU LIKED OR FOUND HELPFUL DURING YOUR STAY HERE?--	--WHAT WERE THE THINGS YOU DIDN'T LIKE OR WEREN'T HELPFUL DURING YOUR STAY HERE?--
. *I thought that this was an excellant workshop. This is honestly the first workshop where I didn't care if we took a break or not. This gave me so many things to think about: not making it my problem - keeping some humor in the situation - feeling more comfortable in telling parents to control their kids - etc. This workshop had a lot of basic useful ideas.*	1. *There wasn't too much that I didn't like - I even got into role-playing which I usually feel really uncomfortable with.*
2. *The last family role play - other role plays were also helpful, even though I'm very uncomfortable in role plays. This feeling was discussed at length in my last role play session. Helped me to understand myself in them more. "Lecturing"*	2. *I'm not saying this was a perfect workshop. but I'm having a tough time thinking of something I really was unhappy with - Excellent Job!!!*
3. *Presenting was very good. Information was helpful to try to use at work. Nice meeting place. Enthusiastic, likeable presenters.*	3. *There was a lot of good material presented but so fast it was hard to absorb it all.*
4. *Materials presented were very helpful because my knowledge of "family therapy" is/was limited. The role playing "practices" were good to try and implement the techniques*	4. *I don't always like the role play situations, but I feel they are necessary and helpful to me. I need to put myself into those situations and try to become more comfortable with myself in them.*
5. *Role playing - learn more from actual practice. Handouts are always helpful for future use like just discussing actual cases. Learned many new techniques for therapy.*	5. *Chairs were too hard - each session was too long - would lose interest at times.*
6. *Really liked therapists, especially Deb Would feel very comfortable with her treating any families I work with. Material was presented in an understandable way. Therapists were helpful when we attempted role playing. Really would like to have more sessions on this!*	6. *Smaller group might be better.* *More pleasant location.*
7. *You guys are down to earth and understandable. Its the first time I've heard anything about family therapy that I can figure out (maybe) at least its somewhere to start. Thanks for the sessions. It seems crazy to have to work at being yourself, but I notice during role plays I'm a "social worker" Looking at the process is hard. I realize how much problem solving I try to do and its easier now to admit it doesn't work.*	7. *I felt confused during the role plays. I didn't like it, but it was probably helpful (especially when I was therapist).*
. *Combination of explaining purpose and practical application was effective medium for learning.*	8. *No answer*

EXHIBIT ff

Participant Evaluations of FTI Workshop

LIKED	DIDN'T LIKE
9. Role playing, concrete techniques, handouts "over all" - excellent workshop - material well organized.	9. Deb - slow down just a little sometimes "too many alternatives" (flexibility) given to group - makes for disorganization at times.
10. Watching you guys work and others work and then trying to do some myself. However I think when were trying to do the therapy ourselves, I think we need more supervision or coaching while trying to do the therapy ourselves. Plus I think if you would be didactic, then model, then have us work with supervision, it would be more effective in so far as the training is concerned. I also think the time frame 2 days is too short in order to accomplish this. I would suggest a time frame of 5 days.	10. no answer
11. I liked the outline for the first family interview and the proceedure steps for therapy. When you don't know what you're doing a guide helps. I also liked some of the technique tools and pat remarks that were shared by the teachers. I enjoyed the humor!	11. Flies
12. The therapy approach presented is practical and useful. Some therapy approaches I have not found practical or useful in the setting where I work. I enjoyed Deb's presentations and the role playing where she and Ardys were the therapists. I felt I learned more observing their sessions than our own role-playing sessions. I thoroughly enjoyed Deb's enthusiasm and sincerity.	12. Too much role-playing. Some is okay. In some role playing sessions people got carried away talking about individual problems or cases they were involved in and we really weren't accomplishing the goal in the role-playing as being a learning experience.
13. I'm very happy with this type of program. Needed this type of general presentation concerning family therapy - in developing my own practice. Possibly will use some of this information and apply it toward work in this area. I want to apply the process toward the family of the alcoholic.	13. I was pleased with the location, but felt that room left much to be desired - sound transmission, flies - possibly it was somewhat destracting. I also felt that board used for writing should have been larger. Content of workshop. I would like a bit more structure, but not to stage restriction I also felt that more definition should have been undivided within structure of program.
14. The information I learned was helpful in that it is down-to-earth, common sense material that I can actually use! It's restored my self-confidence in what the heck my role should be with people I work with. Deb obviously knows her material, but beyond that, has the capacity to teach others.	14. The location was distracting - the heat and flies. Ard seemed ill at ease and unsure of herself.

EXHIBIT ff

	LIKED	DIDN'T LIKE
15.	I felt the workshop was very helpful as I learned a new approach to counseling. I liked the idea of being honest with clients about what we as therapists are thinking about the family relationships. It was a fun time, but also a time of learning. Family sculpturing and joining are things I have never used before but am anxious to try.	no answer.
16.	Some refreshing new methods and concepts - I like the concept of dealing with the whole family, emphasizing family structure "parents have to be parents" appreciated: sculpting, mapping - "use of self" - need to be reminded not to be child-savers and to leave the social worker's hat in the outer office - I think you also gave us some renewed faith in ourselves. You didn't give us the stone tablets - thanks for that.	no answer
17.	The openness of the people - the material - the group sessions - the role plays - the explanations. Very Good!	no answer
18.	It was very comforting to hear that I, as a therapist, don't have enough power to hurt a family and that I might help. The workshop's content was excellent and the fantastic enthusiasm of Deb, Ardys and Carole really got it across. They're excited about what they are and it rubbed off on me. I'm going to try it! Thank you for the opportunity.	Didn't like the flies - could have had more spaces - no center posts and softer chairs. What I'm trying to say that all my complaints were with the physical facilities and they were minor. I would like to observe this with a real family.
19.	I thought you were both excellent - incredible!! "outstanding" leaders. Although I don't really do a lot of counseling therapy I found the sessions and materials presented very helpful in understanding my own personal family conflicts and I know that what I have absorbed from the workshop will be beneficial in understanding and working with present and future case situations.	The role-play situations were difficult for me in that I found myself saying things just to impress fellow workers and found myself getting lost and confused with my role. I feel that it is important to remain myself in dealing with case situations rather than trying to act the "social worker" - "therapist" role. I felt somewhat uncomfortable with Deb's approach - "very direct".

EXHIBIT ff